

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10902

10917

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>27 Shaw Street</u>		d. STREET ADDRESS <u>27 Shaw Street</u>	
3. NAME OF DECEASED (Type or print) <u>Ernest Anderson</u>		4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Anderson</u>		14. MOTHER'S M maiden name <u>Victoria Queen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-0886</u>	
17. INFORMANT <u>Eliza Jones Crononville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/12/59</u> to <u>10/23/59</u> , that I last saw the deceased alive on <u>10/23/59</u> , and that death occurred at <u>10/23/59</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. P. Beckwith</u>		ADDRESS (Street, city or town, state) <u>110-6477 ST THOMAS APTS MD.</u> DATE SIGNED <u>10/23/59</u>	
PHYSICIAN'S NAME (Type) <u>William Reese #108 Wash St Annapolis</u>		22a. LOCATION (City, town, or county) (State) <u>Chesterfield Md</u>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22c. DATE THEREOF <u>10-27-59</u>	
22d. NAME OF CEMETERY OR CREMATORY <u>Mt. Sabor</u>		22e. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #108 Wash St Annapolis</u>		24. REC'D BY REGISTRAR <u>10-29-59</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur S. Krum</u>			

10015

STATE OF NEW YORK

CERTIFICATE OF DEATH

10015

10015

10015

10015

10015

10015

10015

10015

10015

10015

10958

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cl. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.D. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arundel Gardens</u>	c. LENGTH OF STAY IN 1b <u>6 ym.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arundel Gardens</u> <u>MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>522 Holy Cross Rd.</u>		d. STREET ADDRESS <u>522 Holy Cross Road</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>Baer</u> Middle <u>Baer</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9 - 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob DeBeer</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mr. Char. W. Baer</u>		Address <u>36 N. Dudley Ave. (13)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>447X Hypertensive vascular disease</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>
21. I certify that I attended the deceased from <u>November, 1955</u> to <u>Oct 13, 1959</u> , that I last saw the deceased alive on <u>Oct 13, 1959</u> , and that death occurred at <u>9:30 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florian P Nadolski</u>		DATE SIGNED <u>Oct 16, 59</u>	
PHYSICIAN'S NAME (Type) <u>Florian P Nadolski</u>		ADDRESS (Street, city or town, state) <u>2703 Hammond Perry Rd Baltimore</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10/19/59</u>	<u>Landon Park Cem.</u>	<u>3801 Fred Ave.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Low</u>		ADDRESS <u>901 Hollan St</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>OCT 19 59</u>		<u>  </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION SERVICE GRADE RANK BRANCH COMPANY REGIMENT DIVISION CORPS SERVICE NUMBER GRADE RANK BRANCH COMPANY REGIMENT DIVISION CORPS SERVICE NUMBER		SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION SERVICE GRADE RANK BRANCH COMPANY REGIMENT DIVISION CORPS SERVICE NUMBER
CAUSE OF DEATH 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900. 901. 902. 903. 904. 905. 906. 907. 908. 909. 910. 911. 912. 913. 914. 915. 916. 917. 918. 919. 920. 921. 922. 923. 924. 925. 926. 927. 928. 929. 930. 931. 932. 933. 934. 935. 936. 937. 938. 939. 940. 941. 942. 943. 944. 945. 946. 947. 948. 949. 950. 951. 952. 953. 954. 955. 956. 957. 958. 959. 960. 961. 962. 963. 964. 965. 966. 967. 968. 969. 970. 971. 972. 973. 974. 975. 976. 977. 978. 979. 980. 981. 982. 983. 984. 985. 986. 987. 988. 989. 990. 991. 992. 993. 994. 995. 996. 997. 998. 999. 1000. 1001. 1002. 1003. 1004. 1005. 1006. 1007. 1008. 1009. 1010. 1011. 1012. 1013. 1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100. 1101. 1102. 1103. 1104. 1105. 1106. 1107. 1108. 1109. 1110. 1111. 1112. 1113. 1114. 1115. 1116. 1117. 1118. 1119. 1120. 1121. 1122. 1123. 1124. 1125. 1126. 1127. 1128. 1129. 1130. 1131. 1132. 1133. 1134. 1135. 1136. 1137. 1138. 1139. 1140. 1141. 1142. 1143. 1144. 1145. 1146. 1147. 1148. 1149. 1150. 1151. 1152. 1153. 1154. 1155. 1156. 1157. 1158. 1159. 1160. 1161. 1162. 1163. 1164. 1165. 1166. 1167. 1168. 1169. 1170. 1171. 1172. 1173. 1174. 1175. 1176. 1177. 1178. 1179. 1180. 1181. 1182. 1183. 1184. 1185. 		



## CERTIFICATE OF DEATH

Reg. Dist. No.

10918

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>10</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>601 Creekview Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Paul</b> Last <b>BEALL</b>				4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1882</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	IF UNDER 24 HRS. Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew R. Paul</b>				14. MOTHER'S MAIDEN NAME <b>Adeline Patch</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		INFORMANT <b>Mrs. Ollie M. Beall</b>		Address <b>#2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>hypertricular failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>atherosclerotic cardiovascular disease</b> DUE TO (c) <b>10 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>59</b> , to <b>Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 17</b> , 19 <b>59</b> , and that death occurred at <b>11:48 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 Cathedral St., Annapolis, Md.</b> DATE SIGNED <b>10/19/59</b> ACTUAL SIGNATURE <b>John H. Hedeman</b> M.D. PHYSICIAN'S NAME (Type) <b>John Hedeman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 22-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Des Moines Iowa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Taylor &amp; Sons</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

STATE OF TEXAS

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

10959

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverside Beach</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverside Beach</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>257 Grindel Rd.</u>		d. STREET ADDRESS <u>257 Grindel Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>DEWEY</u> First <u>H. BECKHAM</u> Middle Last		4. DATE OF DEATH <u>OCT. 25</u> Month Day Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-16</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Oscar W</u>		14. MOTHER'S MAIDEN NAME <u>Laura Hunter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579 H-1667</u>	
17. INFORMANT <u>Family</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> <u>241 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>STATUS ASTHMATICUS</u> DUE TO (c) <u>BRONCHIAL ASTHMA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>24 HRS</u> <u>43 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CACHEXIA</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>OCT 22</u> , 19 <u>59</u> , to <u>OCT 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>OCT 24</u> , 19 <u>59</u> , and that death occurred at <u>6 A M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mountain Rd.</u> DATE SIGNED <u>10-25-59</u>			
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u>		M.D. <u>Mountain Rd.</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR MD.</u> <u>Pasadena, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>10-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Flow Green</u>	22d. LOCATION (City, town, or county) (State) <u>Flow Green Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGully Funeral Homes</u>		ADDRESS <u>1206 30th St</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1007

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

10022

File No. 100

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15, 1900</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. NAME OF SPOUSE <i>Jane Doe</i>		9. DATE OF MARRIAGE <i>Jan 1, 1925</i>		10. PLACE OF MARRIAGE <i>Baltimore, Md.</i>		11. CAUSE OF DEATH <i>Heart Disease</i>		12. DATE OF DEATH <i>Jan 10, 1945</i>	
13. PLACE OF DEATH <i>Home</i>		14. TIME OF DEATH <i>10:00 AM</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF SPOUSE <i>Jane Doe</i>		17. SIGNATURE OF PHYSICIAN <i>Dr. Smith</i>		18. SIGNATURE OF REGISTRAR <i>John Doe</i>	
19. PLACE OF INTERMENT <i>St. Mary's Cemetery</i>		20. TIME OF INTERMENT <i>11:00 AM</i>		21. SIGNATURE OF INTERMENT SOCIETY <i>St. Mary's</i>		22. SIGNATURE OF BURIAL SOCIETY <i>St. Mary's</i>		23. SIGNATURE OF FUNERAL HOME <i>St. Mary's</i>		24. SIGNATURE OF CEMETERY <i>St. Mary's</i>	
25. PLACE OF BURIAL <i>St. Mary's Cemetery</i>		26. TIME OF BURIAL <i>11:00 AM</i>		27. SIGNATURE OF BURIAL SOCIETY <i>St. Mary's</i>		28. SIGNATURE OF FUNERAL HOME <i>St. Mary's</i>		29. SIGNATURE OF CEMETERY <i>St. Mary's</i>		30. SIGNATURE OF REGISTRAR <i>John Doe</i>	

10960

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN lb <u>3 years</u> <u>8mo. 12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>174 Chestnut Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wilbur</u> Middle Last <u>Bell</u>				4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1904</u>		9. AGE (In years last birthday) yrs. <u>55</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Bell</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Bantt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO <u>Cancer of Penis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. DUE TO <u>With Metastasis in the Bladder</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome with Alcoholism</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. 19---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from <u>2/16</u> , 19 <u>56</u> , to <u>10/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/28</u> , 19 <u>59</u> , and that death occurred at <u>2:10 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>L. Benedict, M. D.</u> M.D. <u>Crownsville State Hospital, Md.</u> <u>10/28/59</u> PHYSICIAN'S NAME (Type) <u>Crownsville State Hospital, Md.</u> <u>10/28/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Oct 31 1959</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Bell</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. B. Johnson</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 30 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18300

STATE OF MARYLAND

CERTIFICATE OF DEATH

18300

NOTION

NOTION

NOTION

NOTION

NOTION

NOTION

NOTION

NOTION

NOTION



10961

## CERTIFICATE OF DEATH

10907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>1 year 3mo. 1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Harrison</u> Last <u>Best</u>				4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1870?</u>	
9. AGE (In years last birthday) <u>89?</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Best</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Brain Syndrome Associated with Arteriosclerosis with Psychosis</u> (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>since admission</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> <u>  </u> <u>  </u> 19 <u>  </u> p. m. <u>  </u> <u>  </u> <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u> <u>  </u> <u>  </u> <u>  </u>	
20f. (City or town) <u>  </u> <u>  </u> <u>  </u>				(County) (State)			
21. I certify that I attended the deceased from <u>7/23</u> , 19 <u>58</u> , to <u>10/24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/24</u> , 19 <u>59</u> , and that death occurred at <u>12:10</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u>			
DATE SIGNED <u>10/26/59</u>							
PHYSICIAN'S NAME (Type) <u>L. Benedict, M. D.</u>				Crownsville State Hospital, Md. <u>10/26/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Milton G. Elicker</u>				ADDRESS <u>1129 N. Caroline St.</u>		24a. REC'D BY REGISTRAR <u>OCT 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

10881

16007

1

I, the undersigned, being a duly qualified Medical Officer of Health for the City and County of New York, do hereby certify that  
 the within and foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the Department of Health, City and County of New York.  
 In testimony whereof, I have hereunto set my hand and the seal of the Department of Health, at New York, this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.  
 \_\_\_\_\_  
 Medical Officer of Health

10919

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Churchton</b>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mollie</b> Middle <b>BLUNT</b> Last <b>BLUNT</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-19-1895</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Daniel Blunt</b>		14. MOTHER'S MAIDEN NAME <b>Nutton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Informant</b>	
		Address <b>Frank Blunt - Churchton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (b) <b>hypertensive cardiovascular disease</b> lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 2, 1959</b> , to <b>Oct. 2, 1959</b> , that I last saw the deceased alive on <b>Oct. 2, 1959</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>45 Franklin St., Annapolis, Maryland</b> DATE SIGNED <b>10/5/59</b>			
ACTUAL SIGNATURE <b>Edith Rodler</b>		M.D. <b>45 Franklin St., Annapolis, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Edith Rodler</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>10-8-59</b>	<b>Franklin</b>	<b>Churchton, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>	

1  
M  
063  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58

AP

10008

CENTRAL AIR FORCE

10013

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

General Headquarters

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10962

## CERTIFICATE OF DEATH

10909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fort Meade Road</u>				d. STREET ADDRESS <u>Fort Meade Road</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Reuben</u> Middle <u>Boyer</u> Last <u>Boyer</u>				4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 Feb. 1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>80</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Severn, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Webster Boyer</u>				14. MOTHER'S MAIDEN NAME <u>Alice Fredhoeffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>214-38-8141</u>		17. INFORMANT Address <u>Mrs. Dorothy Cbw Severn, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the pancreas</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>0</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1</u> 19 <u>51</u> , to <u>October 10</u> 19 <u>59</u> , that I last saw the deceased alive on <u>October 8</u> 19 <u>59</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>RFD 8 Box 442 Pasadena, Md.</u> DATE SIGNED <u>Oct 10, 1959</u>							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>				PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>14 Oct. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>	

10000

CERTIFICATE OF DEATH

10865

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE PHYSICIAN	
1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. OCCUPATION <i>Teacher</i>	
5. DATE OF DEATH <i>Jan 15, 1950</i>		6. TIME OF DEATH <i>10:30 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>	
9. MANNER OF DEATH <i>Natural</i>		10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
11. SIGNATURE OF REGISTRAR <i>John Doe</i>		12. SIGNATURE OF WITNESSES <i>Mr. &amp; Mrs. J. H. Smith</i>	
13. SIGNATURE OF FUNERAL HOME <i>John Doe</i>		14. SIGNATURE OF BURIAL PLACE <i>St. Mary's Cemetery</i>	
15. SIGNATURE OF INTERVIEWER <i>John Doe</i>		16. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
17. SIGNATURE OF INTERVIEWER <i>John Doe</i>		18. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
19. SIGNATURE OF INTERVIEWER <i>John Doe</i>		20. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
21. SIGNATURE OF INTERVIEWER <i>John Doe</i>		22. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
23. SIGNATURE OF INTERVIEWER <i>John Doe</i>		24. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
25. SIGNATURE OF INTERVIEWER <i>John Doe</i>		26. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
27. SIGNATURE OF INTERVIEWER <i>John Doe</i>		28. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
29. SIGNATURE OF INTERVIEWER <i>John Doe</i>		30. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
31. SIGNATURE OF INTERVIEWER <i>John Doe</i>		32. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
33. SIGNATURE OF INTERVIEWER <i>John Doe</i>		34. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
35. SIGNATURE OF INTERVIEWER <i>John Doe</i>		36. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
37. SIGNATURE OF INTERVIEWER <i>John Doe</i>		38. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
39. SIGNATURE OF INTERVIEWER <i>John Doe</i>		40. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
41. SIGNATURE OF INTERVIEWER <i>John Doe</i>		42. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
43. SIGNATURE OF INTERVIEWER <i>John Doe</i>		44. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
45. SIGNATURE OF INTERVIEWER <i>John Doe</i>		46. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
47. SIGNATURE OF INTERVIEWER <i>John Doe</i>		48. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
49. SIGNATURE OF INTERVIEWER <i>John Doe</i>		50. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
51. SIGNATURE OF INTERVIEWER <i>John Doe</i>		52. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
53. SIGNATURE OF INTERVIEWER <i>John Doe</i>		54. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
55. SIGNATURE OF INTERVIEWER <i>John Doe</i>		56. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
57. SIGNATURE OF INTERVIEWER <i>John Doe</i>		58. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
59. SIGNATURE OF INTERVIEWER <i>John Doe</i>		60. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
61. SIGNATURE OF INTERVIEWER <i>John Doe</i>		62. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
63. SIGNATURE OF INTERVIEWER <i>John Doe</i>		64. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
65. SIGNATURE OF INTERVIEWER <i>John Doe</i>		66. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
67. SIGNATURE OF INTERVIEWER <i>John Doe</i>		68. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
69. SIGNATURE OF INTERVIEWER <i>John Doe</i>		70. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
71. SIGNATURE OF INTERVIEWER <i>John Doe</i>		72. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
73. SIGNATURE OF INTERVIEWER <i>John Doe</i>		74. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
75. SIGNATURE OF INTERVIEWER <i>John Doe</i>		76. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
77. SIGNATURE OF INTERVIEWER <i>John Doe</i>		78. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
79. SIGNATURE OF INTERVIEWER <i>John Doe</i>		80. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
81. SIGNATURE OF INTERVIEWER <i>John Doe</i>		82. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
83. SIGNATURE OF INTERVIEWER <i>John Doe</i>		84. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
85. SIGNATURE OF INTERVIEWER <i>John Doe</i>		86. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
87. SIGNATURE OF INTERVIEWER <i>John Doe</i>		88. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
89. SIGNATURE OF INTERVIEWER <i>John Doe</i>		90. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
91. SIGNATURE OF INTERVIEWER <i>John Doe</i>		92. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
93. SIGNATURE OF INTERVIEWER <i>John Doe</i>		94. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
95. SIGNATURE OF INTERVIEWER <i>John Doe</i>		96. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
97. SIGNATURE OF INTERVIEWER <i>John Doe</i>		98. SIGNATURE OF INTERVIEWER <i>John Doe</i>	
99. SIGNATURE OF INTERVIEWER <i>John Doe</i>		100. SIGNATURE OF INTERVIEWER <i>John Doe</i>	

RECEIVED

10000



Items 3, 12 Film 250 10-14-59 et

10963

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>M.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>AD.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glean Bulwae</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glean Bulwae</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>200 Kent Rd.</u>		d. STREET ADDRESS <u>200 Kent Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>BRAZASKAS</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>5</u> - Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1902</u> 9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>LITH.</u>
12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>		13. FATHER'S NAME <u>PETER MAZIAKAS</u>	
14. MOTHER'S MAIDEN NAME <u>?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address <u>Family Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1750 Uremia</u> DUE TO (b) <u>Adenocarcinoma of Right Ovary</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1 1/2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January</u> , 19 <u>59</u> , to <u>October 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>October 5</u> , 19 <u>59</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>E. Roderick Shipley</u> M.D.			
PHYSICIAN'S NAME (Type) <u>E. Roderick Shipley M.D. Medical Arts Bldg. Balto.-Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>B.</u>	<u>10.9.59</u>	<u>Holy Red.</u>	<u>Balto.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clary - 130 E. Teat Ave.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>OCT 8 '59</u>	<u>Clary &amp; Sons</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

40



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10911

Reg. Dist. No.

10964

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Glen</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same Md.</u> b. COUNTY <u>Same A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same Pasadena</u> d. STREET ADDRESS <u>Forest Glen Rd. Same Route 1, Box 307</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>William Bricker</u> P. First Middle Last				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>15th.</u> Year <u>19 59</u>											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2/25/95</u>		<b>9. AGE</b> (In years last birthday) <u>64</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman and Collector</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Littlepage Furniture Co.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Berkley County W. Va.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Geramine Bricker</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Virginia Brooke</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>215-07-9831</u>				<b>17. INFORMANT</b> Address <u>Box 307, Pasadena, Md</u> <u>Mrs. Virginia Bricker (wife)</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>EXAMINER'S NAME (Type)</b> <u>Gustave H. Faubert, M.D.</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>10/16/59</u>						<b>DATE SIGNED</b>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Oct. 19/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Western</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore, Md.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Witzke Funeral Directors</u> <u>4101 Edmondson</u>						<b>24a. REC'D BY REGISTRAR</b>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u>					
<b>DATE</b> <u>OCT 19 '59</u>						<b>DATE</b>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10965

## CERTIFICATE OF DEATH

10912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>9mo. 8days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>RFD 2, Box 90</b>	
3. NAME OF DECEASED (Type or print) <b>Keziah</b>		First		Middle		Last <b>Brown</b>		4. DATE OF DEATH Month <b>10</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1870</b>		9. AGE (In years last birthday) yrs. <b>88</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Decubital Ulcers</b> DUE TO (c) <b>Arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Arteriosclerosis</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) (State)	
21. I certify that I attended the deceased from <b>1/8</b> , 19 <b>59</b> , to <b>10/16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/16</b> , 19 <b>59</b> , and that death occurred at <b>12:36</b> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b>		M.D. <b>Crownsville State Hospital, Md.</b> <b>10/16/59</b> ADDRESS (Street, city or town, state) DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>		<b>Crownsville State Hospital, Md.</b> <b>10/16/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Oct 18 1959</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Int. Calvary</b>		22d. LOCATION (City, town, or county) <b>Arnold</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. B. Johnson</b>				ADDRESS <b>Annapolis</b>		24a. REC'D BY REGISTRAR <b>OCT 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. H...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **10913**

1. PLACE OF DEATH a. COUNTY <b>A. A.</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A. A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>99 EAST ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>Briscoe</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-18-1891</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>19</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <b>ANNAPOLIS-Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN BRISCOE</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-30-9975</b>	
17. INFORMANT <b>Joseph Brown-99 East St.</b>		Address <b>ANNAPOLIS-Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>434.4</b> DUE TO <b>Cholera Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> DUE TO (c) <b>Sudden</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . <b>S. Linhardt</b> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>F. Linhardt</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>10/20/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10-22-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>U.S. NATIONAL</b>	22d. LOCATION (City, town, or county) (State) <b>ANNAPOLIS Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III</b>		24a. REC'D BY REGISTRAR <b>OCT 26 '59</b>	
ADDRESS <b>ANNAPOLIS-Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

10914

10966

1. PLACE OF DEATH o. COUNTY <u>A.A.</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendship</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Friendship</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mable</u> Middle <u>S</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9</u>		9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Brown</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Smothers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>314-44-3828</u>		17. INFORMANT Address <u>Landers Brown, Friendship, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 13</u> , 19 <u>59</u> to <u>Oct 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 18</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u>				ADDRESS (Street, city or town, state) <u>110-CLAY ST. ANNAPOLIS, Md.</u>		DATE SIGNED <u>10/19/59</u>	
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-21-59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Sumner Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. S. Sewell, Jr. Fred, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

tem 18-59 film 253  
12-3-59 ams

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10915

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>57 Northwest Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SYLVIA A. BROWN</b>		4. DATE OF DEATH <b>October 15, 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-19-1940</b>
9. AGE (In years last birthday) <b>19</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Richard Brown</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Murry</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Richard Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		17. INFORMANT <b>New London Conn.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Syncope during operation for pelvic peritonitis</b> DUE TO (b) <b>950 X</b> Conditions, if any, which gave rise to immediate cause (c) <b>950 X</b> DUE TO (c) <b>950 X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Syncope during operation (Therapeutic misadventure)</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>10/14/59</b> p.m. <b>10:15</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) <b>Annapolis</b> (County) <b>AA</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED <b>10/15/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-18-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		22d. LOCATION (City, town, or country) <b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR <b>William Reese #108 Wash St Annapolis Md.</b>		24a. REC'D BY REGISTRAR <b>Anna M.</b>	
		24b. REGISTRAR'S SIGNATURE <b>Anna M.</b>	

DATE **Oct 19 59**



10001

STATE OF TEXAS  
COUNTY OF DALLAS  
CITY OF DALLAS  
DEPARTMENT OF HEALTH  
BIRTH CERTIFICATE

10001

A-2-11

*William H. H. H.*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 12108

10967

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>11 yrs. 3 mo. 8 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>426 N. Caroline Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ella Camper</b>		4. DATE OF DEATH Month Day Year <b>10 23 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1888?</b>
9. AGE (In years last birthday) yrs. <b>71?</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>422.1</b> DUE TO <b>Arteriosclerotic Cardio-</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>vascular Disease</b> DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year <b>How - - - 19 - - -</b> p. m.		20d. INJURY OCCURRED While Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/15</b> , 19 <b>48</b> , to <b>10/23</b> , 19 <b>59</b> , that I lost s/he the deceased alive on <b>10/23</b> , 19 <b>59</b> and that death occurred at <b>7:35 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Hildegard Heard Reissman M.D. Crownsville State Hospital, Md. 10/23/59</b>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md. 10/23/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10/27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. CATHARY Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Cedar Hill Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Wilson</b>		ADDRESS <b>1000 Brantley Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2015

RECEIVED

1968

RECEIVED  
JAN 10 1968  
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE  
OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS  
WASHINGTON, D.C. 20460

TO: DIRECTOR, CENTER FOR DISEASE CONTROL AND PREVENTION  
FROM: [illegible]  
SUBJECT: [illegible]

Enclosed for the Center for Disease Control and Prevention are two copies of a report titled "The Role of the Health Care System in the Control of Infectious Diseases". The report was prepared by the [illegible] and is dated [illegible]. It discusses the importance of the health care system in the control of infectious diseases and provides recommendations for improving the system's effectiveness. The report is being submitted to you for your review and comment.

## CERTIFICATE OF DEATH

Reg. Dist. No. 10916

10922

1. PLACE OF DEATH a. COUNTY <u>ANNAPOLIS</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE CITY</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	c. LENGTH OF STAY IN 1b <u>8 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3401-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u>		d. STREET ADDRESS <u>1313 Stonewood Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>LEE</u> Last <u>COCHRAN</u>		4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 Jan., 1916</u>
9. AGE (In years lost birthday) yrs. <u>43</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>F.B.I.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>HARRY W. COCHRAN</u>	
14. MOTHER'S MAIDEN NAME <u>BEATRICE MURPHY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>KATHRINE M. COCHRAN 1313 STONEWOOD RD.,</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE <del>XXXX</del> NECROTIZING PANCREATITIS</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>5 October, 1959</u> , to <u>14 October, 1959</u> , that I last saw the deceased alive on <u>14 October, 1959</u> , and that death occurred at <u>4:35 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u> DATE SIGNED <u>10-15-59</u> ACTUAL SIGNATURE <u>R.C. Laning</u> PHYSICIAN'S NAME (Type) <u>R.C. LANING LCDR MC USN</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>LONG GREEN MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>MORAN FUNERAL HOME 3000 E. Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10968

## CERTIFICATE OF DEATH

10917

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft Geo G Meade</b>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>19 59</b>				5. SEX <b>M</b> 6. COLOR OR RACE <b>Cau</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>30 Oct 59</b> 9. AGE (In years last birthday) yrs. <b>7</b> Min. <b>18</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>BOBBY LEE COLLINS Sr</b>				14. MOTHER'S MAIDEN NAME <b>MARY R JENNINGS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b> (If yes, give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>(Father) SP5 Bobby L Collins</b>				Address <b>Co A 19th Engr BN Ft Geo G Meade Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO <b>776x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> DUE TO (c) <b>-</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>-</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>30 Oct 19 59</b> to <b>30 Oct 19 59</b> , that I last saw the deceased alive on <b>30 Oct 19 59</b> , and that death occurred at <b>10, 20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Army Hospital</b> DATE SIGNED <b>31 Oct 59</b> ACTUAL SIGNATURE <b>Nathaniel S. Beard, Jr</b> M.D. <b>U.S. Army Hospital</b>							
PHYSICIAN'S NAME (Type) <b>NATHANIEL S BEARD Jr Capt M.C.</b> <b>FT GEO G MEADE, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>31 Oct '59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laboratory, U.S. Army Hospital, Fort George G. Meade, Md</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Betty M. Ellis, Capt., MSC</b>				24a. REC'D BY REGISTRAR <b>NOV 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kross</b>	

2050261XUO

CERTIFICATE OF DEATH

1968

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]	
DATE OF BIRTH [Faint text, possibly "01/01/1920"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Maryland"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "08/15/1968"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		SIGNATURE OF PHYSICIAN [Faint signature]	
SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
ADDRESS OF DECEASED [Faint text, possibly "123 Main St, Baltimore, MD"]		ADDRESS OF PHYSICIAN [Faint text, possibly "456 Oak St, Baltimore, MD"]	
ADDRESS OF REGISTRAR [Faint text, possibly "789 Pine St, Baltimore, MD"]		ADDRESS OF WITNESS [Faint text, possibly "101 Elm St, Baltimore, MD"]	

1

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN WHO HAS EXAMINED THE DECEASED AND WHO IS A MEMBER OF THE MARYLAND MEDICAL SOCIETY. IT IS NOT VALID IF SIGNED BY A PHYSICIAN WHO IS NOT A MEMBER OF THE MARYLAND MEDICAL SOCIETY.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10918

Reg. Dist. No.

10969

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Magothy Beach, Pasadena</u> c. LENGTH OF STAY IN 1b <u>20 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Riverside Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Alice Mary Collins</u> (2nd) (1st) First Last Middle				<b>4. DATE OF DEATH</b> <u>October 12th.</u> 19 <u>59</u> Month Day Year											
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7/25/12</u>		<b>9. AGE</b> (In years last birthday) <u>47</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b> <u>Frank Hoerke</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Russell</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>				<b>17. INFORMANT</b> <u>Leo Trageser (Son)</u> Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>															
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert, M.D.</u> <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>												<b>DATE SIGNED</b>			
<b>EXAMINER'S NAME (Type)</b> <u>Gustave H. Faubert, M.D.</u>												<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>10/12/59</u>															
<b>22a. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>14 Oct. 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven Cemo</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Glen Burnie, Maryland</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. V. Singleton</u> <b>ADDRESS</b> <u>Glen Burnie, Md.</u>												<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Klaus</u>	
<b>DATE</b> <u>OCT 15 '59</u>															

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10919

# CERTIFICATE OF DEATH

10923

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>AA CO.</u>		MARYLAND		STATE <u>MA</u>		COUNTY <u>AA CO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place) <u>10/14-10/26</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WOODROW BEACH</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOMECWOOD. CON. HOME.</u>				STREET ADDRESS (If rural give location) <u>SHORE DRIVE</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>MARGARET</u> (First) <u>CONNEX</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>10</u> (Day) <u>26</u> (Year) <u>1959</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Jan. 19, 1902</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hairdresser</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Lokey</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. -- ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>William M. Conner Edgewater, Md. Chesapeake Dr. Rt. 343, Box 3</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
199.2 IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1957-1959</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 19, 1957</u> , to <u>10/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/26/59</u> , and that death occurred at <u>8:20</u> M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED <u>10/26/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>10-29-59</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>1756 Pa ave NW Wash D.C.</u>			



10924

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>24 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>275 Smith Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Louis</u> Last <u>EIRING</u>				4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-13-92</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>USN</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Henry EIRING</u>				14. MOTHER'S MAIDEN NAME <u>Eva HEROLD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>USNH Annapolis, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>ARTEIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 Hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that I last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>USNH Annapolis, Md.</u> DATE SIGNED <u>10-3-59</u>							
ACTUAL SIGNATURE <u>R. J. Busse Jr</u> M.D. <u>USNH Annapolis, Md.</u>				19-3-59			
PHYSICIAN'S NAME (Type) <u>R. J. BUSSE JR LT MC USN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct-6-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOTE: The deceased was a known cardiac who received regular outpatient care at this hospital. Date of last visit: 1 Oct 1959



ISQI



10925

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>8 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. STREET ADDRESS <b>1 Mason's Beach</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BELE Anna</b> First <b>PALMER</b> Middle <b>ERB</b> Last				4. DATE OF DEATH Month <b>October</b> Day <b>12</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 8, 1874</b>	
9. AGE (In years lost birthday) <b>85</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>yes</b> INFORMANT <b>Arthur P. Erb, Son, Deale, Md</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pancreatitis &amp; hemorrhagic pneumonia</b> 584X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute cholecystitis &amp; peri-cystic abscess &amp; extension to pancreas</b> DUE TO (c) <b>?</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nephrosclerosis, osteoarthritis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 12, 1959</b> , to <b>Oct 12, 1959</b> , that I last saw the deceased alive on <b>Oct 12, 1959</b> , and that death occurred at <b>11:50 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Willard F. Smith</b> M.D.				ADDRESS (Street, city or town, state) <b>Shadyside, Md.</b> DATE SIGNED <b>10/13/59</b>			
PHYSICIAN'S NAME (Type) <b>Willard F. Smith</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-15-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Congressional</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. Inc. Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>OCT 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

1  
X  
M  
063  
1  
2  
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10322

DATE OF DEATH

10322

PLACE OF DEATH

10322

CAUSE OF DEATH

10322

AGE

10322

SEX

10322

EDUCATION

10322

OCCUPATION

10322

RELIGION

10322

MARRIAGE

10322

PREVIOUS ILLNESS

10322

PREVIOUS SURGERY

10322

PREVIOUS TRAUMA

10322

PREVIOUS DRUGS

10322

PREVIOUS ALCOHOL

10322

PREVIOUS TOBACCO

10322

PREVIOUS OTHER

10322

PREVIOUS OTHER

10322

PREVIOUS OTHER

10322

PREVIOUS OTHER

10322



1000

CERTIFICATE OF DEATH

10000

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]



[Faint, mostly illegible text at the bottom of the page, possibly a continuation of the certificate or a separate document.]

10927

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hospital</u>		d. STREET ADDRESS <u>98 Monticello Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH E. FRANK</u>		4. DATE OF DEATH Month Day Year <u>OCT 24 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25<sup>th</sup> 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph J. Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Elliott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>George C. Frank #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary embolism</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>59</u> , to <u>October</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 23</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John C. Hedeman</u> M.D. <u>Annapolis Md</u> PHYSICIAN'S NAME (Type) <u>John C. Hedeman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR, SON</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 27 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1903

1903

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Signature of coroner



10970

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A. A.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>A. A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carvel Beach</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carvel Beach</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>458 Carvel Beach Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>MAE</b> Last <b>FRYFOGLE</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>1,</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 30, 1908</b>
9. AGE (In years lost birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles W. Lochhead</b>		14. MOTHER'S MAIDEN NAME <b>Mabel Britton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>217-16-7622</b>	
17. INFORMANT <b>Mr. A. Carney Fryfogle - 458 Carvel Beach Rd.</b>		Address <b>Carvel Beach, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>Crony Aneurysm</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b> <b>1 Hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus; Carcinoma of Cervix</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 12, 1956</b> to <b>Sept. 22, 1959</b> , that I lost s/he the deceased alive on <b>Sept 22, 1959</b> , and that death occurred at <b>P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Medford Ave. Beesley, Md.</b> DATE SIGNED <b>10/2/59</b>			
ACTUAL SIGNATURE <b>Sylvia D. Greenberg</b>		M.D. <b>Medford Ave. Beesley, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Vickers &amp; Sons - Balt 17</b>		24a. REC'D BY REGISTRAR <b>OCT 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

RESEARCH REPORT 2007-01

..

1022

DOI: 10.1002/for

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10971

10925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Pasadena, MD.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rock Creek - Ft. Smallwood Rd.</b>				d. STREET ADDRESS <b>Ft. Smallwood Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sally</b> Middle <b>-</b> Last <b>FURLONG</b>				4. DATE OF DEATH Month <b>10</b> Day <b>4</b> Year <b>1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-16-77</b>	9. AGE (in years lost birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>	
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>122 Co Wellen</b>		Address <b>Annapolis, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiac Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>Oct. 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct. 1</b> , 19 <b>59</b> , and that death occurred at <b>3:00 P.</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Brady Smith</b>				ADDRESS (Street, city or town, state) <b>8471 Ft. Smallwood Rd.</b>		DATE SIGNED <b>10/5/59</b>	
PHYSICIAN'S NAME (Type) <b>J. BRADY SMITH</b>				<b>PASADENA, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-6-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. VETERS.</b>		22d. LOCATION (City, town, or county) (State) <b>Speth</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mc Cully Funeral Homes</b>				ADDRESS <b>130 E. Fort Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 6 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur A. Harris</b>			



10928

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>4 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Louiseanna</b> Middle Last <b>Gambrills</b>		4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-1911</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alke Abrams</b>		14. MOTHER'S MAIDEN NAME <b>Georgeanna Chews</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Horace Gambrills Jones Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro vascular accident</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 1, 1959</b> , to <b>Oct. 1, 1959</b> , that I last saw the deceased alive on <b>Oct. 1, 1959</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. T. Allen</b>		DATE SIGNED <b>10/2/59</b>	
PHYSICIAN'S NAME (Type) <b>A. T. Allen</b>		ADDRESS (Street, city or town, state) <b>62 Cathedral St., Annapolis, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-4-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wayman Wood Home</b>		22d. LOCATION (City, town, or county) (State) <b>Severna Park Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese #108 Wash. St. Annapolis</b>		24a. REC'D BY REGISTRAR <b>ACT 6 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1032

1032

APR 24 1964

RECEIVED  
MAY 1 1964

TO THE DIRECTOR  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

FROM THE DIRECTOR  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

1032



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10972

## CERTIFICATE OF DEATH

10927

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>26-Georgia-Ave, N.W.</u>				d. STREET ADDRESS <u>26-Georgia Ave N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>M.</u> Last <u>Gehne</u>				4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 Feb. 1875</u>	
9. AGE (In years lost birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown (Kuehl)</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Mr. Kindred</u> Address <u>100 Central Ave. Glen Burnie</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>Oct</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-6</u> , 19 <u>59</u> , and that death occurred at <u>9:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. R. MacDonald</u>				ADDRESS (Street, city or town, state) <u>P.O. Box 518</u>			
DATE SIGNED <u>10-12-59</u>							
PHYSICIAN'S NAME (Type) <u>C. R. MacDonald MD</u>				<u>Glen Burnie Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>15 Oct. 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Singleton</u>				ADDRESS <u>Glen Burnie Md</u>		24a. REC'D BY REGISTRAR <u>OCT 15 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

10032

CERTIFICATE OF DEATH

NO. 10032

DATE OF DEATH

DECEASED

DEATH CERTIFICATE  
JAMES BOND

10032

DECEASED

10032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10928

10973

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Riviera Beach</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>266 Carroll - Road</u>				d. STREET ADDRESS <u>266 Carroll - Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Mary</u> Middle <u>E.</u> Last <u>Piblette</u>		4. DATE OF DEATH		Month <u>OCT.</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 Oct. 1886</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Greenwood, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph F. witrow</u>				14. MOTHER'S MAIDEN NAME <u>Florella M<sup>e</sup> Kiraban</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT <u>John F. Piblette, Same as no-(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>Carcinoma nt. Breast</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 YR.</u> <u>2 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>AUG 15</u> , 19 <u>59</u> , to <u>OCT. 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>OCT. 18</u> , 19 <u>59</u> , and that death occurred at <u>2:35 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MOUNTAIN RD.</u> DATE SIGNED <u>PASADENA, MARYLAND</u>							
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u> M.D. <u>PASADENA, MARYLAND</u>							
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>22 Oct. 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Benton Co. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sauk Rapids Minn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware - Glen Burnie, md</u>				24a. REC'D BY REGISTRAR <u>OCT 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Glen E. Kane</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

<p>1. Name of Deceased: <u>John Doe</u></p>		<p>2. Date of Death: <u>10-15-1968</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Sex: <u>Male</u></p>	
<p>5. Race: <u>White</u></p>		<p>6. Marital Status: <u>Married</u></p>	
<p>7. Usual Residence: <u>123 Main St, Baltimore, MD</u></p>		<p>8. Place of Death: <u>Home</u></p>	
<p>9. Cause of Death: <u>Myocardial Infarction</u></p>		<p>10. Manner of Death: <u>Natural</u></p>	
<p>11. Physician: <u>Dr. J. Smith</u></p>		<p>12. Coroner: <u>John Doe</u></p>	
<p>13. Burial Place: <u>Greenwood Cemetery</u></p>		<p>14. Signature of Physician: <u>[Signature]</u></p>	
<p>15. Signature of Coroner: <u>[Signature]</u></p>		<p>16. Date of Filing: <u>10-16-1968</u></p>	

1  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10974** **CERTIFICATE OF DEATH**

10929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				c. LENGTH OF STAY IN 1b <u>29 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Ritchie Highway &amp; Annapolis Rd.</u>				d. STREET ADDRESS <u>Rithie Highway &amp; annapolis Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Walter J. (Goszka)</u> Middle <u>Goska</u> Last				4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 2, 1892</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storkepper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Groceries</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stanley Goszka</u>				14. MOTHER'S MAIDEN NAME <u>Mary Grembocka Severna Park, Md.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>216-34-0084</u>		17. INFORMANT <u>Helen Goska</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>177X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate with metastasis</u> DUE TO <u>Inoperable</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September, 1956</u> , to <u>October, 1959</u> , that I last saw the deceased alive on <u>Oct. 3, 1959</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis I. Codd</u>		M.D. <u>Severna Park, Maryland</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>10-5-59</u>	
PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.Co.Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Fialkowski</u>				ADDRESS <u>2007 Eastern ave.</u>		24a. REC'D BY REGISTRAR <u>OCT 7 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>John J. Raus</u>			







10975

## CERTIFICATE OF DEATH

10930

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft Geo G Meade</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ohio</b>		b. COUNTY <b>Van Wert</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>		e. STREET ADDRESS <b>754 S Walnut St</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>WILSON</b>		Middle <b>ARTHUR</b>		Last <b>GOUTY</b>		4. DATE OF DEATH Month <b>October</b>		Day <b>30</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 December 1885</b>		9. AGE (In years last birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Henry Gouty</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Decker</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>281-10-7676</b>		17. INFORMANT <b>(Son) Sfc Harold Gouty</b>		Address <b>USA Hosp Ft Geo G Meade, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>19 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Van Wert</b>		(County) (State)	
21. I certify that I attended the deceased from <b>30 Oct</b> , 19 <b>59</b> , to <b>30 Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>30 Oct</b> , 19 <b>59</b> , and that death occurred at <b>5:10 P.</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Nathaniel S. Beard</b>		ADDRESS (Street, city or town, state) <b>U.S. ARMY HOSPITAL</b>		DATE SIGNED <b>31 Oct 59</b>					
PHYSICIAN'S NAME (Type) <b>NATHANIEL S. BEARD Jr Capt M.C.</b>		Ft <b>Geo G Meade, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Van Wert, Ohio</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert P. Ware</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF REVENUE

1995

© 2006 The Authors  
Journal compilation © 2006 Blackwell Publishing Ltd

10976

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>				c. LENGTH OF STAY IN 1b <u>9 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>District Training School, Children's Center, Laurel, Md.</u>				d. STREET ADDRESS <u>3905 Burns Place, S.E.</u> 47X-3			
3. NAME OF DECEASED (Type or print) First <u>Steven</u> Middle <u>Anthony</u> Last <u>Greene</u>				4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/7/55</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>59</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Lee Ellis Greene</u>				14. MOTHER'S MAIDEN NAME <u>Gerardine Mary Bryant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT Address <u>Social Service, Children's Center, Laurel, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration with pneumonia</u> 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hydrocyphalus - congenital</u> DUE TO (c) <u>Mental and physical retardation</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/15/59</u> , 19 <u>59</u> , to <u>10/19/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/19/59</u> , 19 <u>59</u> , and that death occurred at <u>1:15</u> a.m., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Glass</u> M.D.				ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md.</u> DATE SIGNED <u>10/19/59</u>			
PHYSICIAN'S NAME (Type) <u>George Glass, M.D.</u>				Children's Center, Laurel, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malman and Lecky</u> ADDRESS <u>424 R St NW</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

10978

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. EDUCATION</p> <p>9. RELIGION</p> <p>10. RACE</p> <p>11. COLOR</p> <p>12. ETHNIC ORIGIN</p> <p>13. SOCIAL CLASS</p> <p>14. INCOME</p> <p>15. HEALTH STATUS</p> <p>16. PREVIOUS ILLNESSES</p> <p>17. CAUSE OF DEATH</p> <p>18. MANNER OF DEATH</p> <p>19. TIME OF DEATH</p> <p>20. PLACE OF DEATH</p> <p>21. SIGNATURE OF DECEASED</p> <p>22. SIGNATURE OF WITNESSES</p> <p>23. SIGNATURE OF PHYSICIAN</p> <p>24. SIGNATURE OF CORONER</p> <p>25. SIGNATURE OF REGISTRAR</p>	
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

10977

## CERTIFICATE OF DEATH

10932

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Glen Burnie, Anne Arundel Co.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Freehold, N.J.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>5 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie, Md. 67x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Plaza Manor Nursing Home</b>		d. STREET ADDRESS <b>Glen Burnie, Maryland</b>	
3. NAME OF DECEASED (Type or print) <b>Annie B. Gregory</b>		4. DATE OF DEATH Month <b>October</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years lost birthday) <b>84 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trained Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>	
11. BIRTHPLACE (State or foreign country) <b>Stanton, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Gladys J. Hawkins-1532 Druid Hill Ave.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Psychosis, Glaucoma.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 8, 1959</b> , to <b>October 31, 1959</b> , that I last saw the deceased alive on <b>October 24, 1959</b> , and that death occurred at <b>8:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>400 N. Carrollton Avenue Balto.</b> DATE SIGNED <b>23</b>			
ACTUAL SIGNATURE <b>James M. Pair</b>		M.D. <b>400 N. Carrollton Avenue Balto.</b>	
PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		<b>Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 4, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Int. Clubhouse</b>	22d. LOCATION (City, town, or county) (State) <b>Cambridge Mass.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holland Funeral Home</b>		24a. REC'D BY REGISTRAR <b>Waymond White</b>	
24b. REGISTRAR'S SIGNATURE <b>Waymond White</b>		DATE <b>NOV 3 '59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10933

## CERTIFICATE OF DEATH

Reg. Dist. No.

10929

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>A.A.Co</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>10</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>203 Gloucester St.</b>		e. STREET ADDRESS <b>203 Gloucester St.</b>	
3. NAME OF DECEASED (Type or print) <b>APHRODITE</b> First Middle Last <b>HALAKUS</b>		4. DATE OF DEATH <b>10</b> Month <b>7</b> Day <b>1959</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b> 9. AGE (In years last birthday) <b>about 18</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>GREECE</b>		12. CITIZEN OF WHAT COUNTRY? <b>GREECE</b>	
13. FATHER'S NAME <b>PETER VOSINAS</b>		14. MOTHER'S MAIDEN NAME <b>K. ROSOKIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>—</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>MRS. THEODORE G. NICHOLS</b> Address <b>#2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446x</b> <b>Azotemia</b> DUE TO <b>Arteriosclerosis Generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Chronic Nephritis</b> (b) <b>Chronic Nephritis</b> (c) <b>Semility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>4 yrs.</b> <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15</b> , 1950, to <b>Oct. 7</b> , 1959, that I last saw the deceased alive on <b>10-7</b> , 1959, and that death occurred at <b>7:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 SHAW ST ANNAPOLIS, MD.</b> DATE SIGNED <b>10-9-59</b>			
ACTUAL SIGNATURE <b>James R. Martin</b>		M.D. <b>6 SHAW ST ANNAPOLIS, MD.</b>	
PHYSICIAN'S NAME (Type) <b>JAMES R. MARTIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>10-9-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST. JAMES</b>	22d. LOCATION (City, town, or county) (State) <b>ANNAPOLIS MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Lefterious</b> ADDRESS <b>Annepolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

CERTIFICATE OF DEATH

10828

Reg. Dist. No.

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1928</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>MD</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. MEDICAL HISTORY <i>None</i>	
16. SIGNATURE OF DECEASED <i>John A. Smith</i>		17. SIGNATURE OF WITNESS <i>John A. Smith</i>		18. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	

19. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		20. SIGNATURE OF CLERK <i>John A. Smith</i>		21. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
22. SIGNATURE OF DECEASED <i>John A. Smith</i>		23. SIGNATURE OF WITNESS <i>John A. Smith</i>		24. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
25. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		26. SIGNATURE OF CLERK <i>John A. Smith</i>		27. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
28. SIGNATURE OF DECEASED <i>John A. Smith</i>		29. SIGNATURE OF WITNESS <i>John A. Smith</i>		30. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
31. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		32. SIGNATURE OF CLERK <i>John A. Smith</i>		33. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
34. SIGNATURE OF DECEASED <i>John A. Smith</i>		35. SIGNATURE OF WITNESS <i>John A. Smith</i>		36. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
37. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		38. SIGNATURE OF CLERK <i>John A. Smith</i>		39. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
40. SIGNATURE OF DECEASED <i>John A. Smith</i>		41. SIGNATURE OF WITNESS <i>John A. Smith</i>		42. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
43. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		44. SIGNATURE OF CLERK <i>John A. Smith</i>		45. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
46. SIGNATURE OF DECEASED <i>John A. Smith</i>		47. SIGNATURE OF WITNESS <i>John A. Smith</i>		48. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
49. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		50. SIGNATURE OF CLERK <i>John A. Smith</i>		51. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
52. SIGNATURE OF DECEASED <i>John A. Smith</i>		53. SIGNATURE OF WITNESS <i>John A. Smith</i>		54. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
55. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		56. SIGNATURE OF CLERK <i>John A. Smith</i>		57. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
58. SIGNATURE OF DECEASED <i>John A. Smith</i>		59. SIGNATURE OF WITNESS <i>John A. Smith</i>		60. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
61. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		62. SIGNATURE OF CLERK <i>John A. Smith</i>		63. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
64. SIGNATURE OF DECEASED <i>John A. Smith</i>		65. SIGNATURE OF WITNESS <i>John A. Smith</i>		66. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
67. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		68. SIGNATURE OF CLERK <i>John A. Smith</i>		69. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
70. SIGNATURE OF DECEASED <i>John A. Smith</i>		71. SIGNATURE OF WITNESS <i>John A. Smith</i>		72. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
73. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		74. SIGNATURE OF CLERK <i>John A. Smith</i>		75. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
76. SIGNATURE OF DECEASED <i>John A. Smith</i>		77. SIGNATURE OF WITNESS <i>John A. Smith</i>		78. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
79. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		80. SIGNATURE OF CLERK <i>John A. Smith</i>		81. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
82. SIGNATURE OF DECEASED <i>John A. Smith</i>		83. SIGNATURE OF WITNESS <i>John A. Smith</i>		84. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
85. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		86. SIGNATURE OF CLERK <i>John A. Smith</i>		87. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
88. SIGNATURE OF DECEASED <i>John A. Smith</i>		89. SIGNATURE OF WITNESS <i>John A. Smith</i>		90. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
91. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		92. SIGNATURE OF CLERK <i>John A. Smith</i>		93. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
94. SIGNATURE OF DECEASED <i>John A. Smith</i>		95. SIGNATURE OF WITNESS <i>John A. Smith</i>		96. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
97. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		98. SIGNATURE OF CLERK <i>John A. Smith</i>		99. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	
100. SIGNATURE OF DECEASED <i>John A. Smith</i>		101. SIGNATURE OF WITNESS <i>John A. Smith</i>		102. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>	

RECEIVED JAN 16 1928

10978

Item 7 Film G249 10-9-59 et

## CERTIFICATE OF DEATH

10934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel Co.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A. A. Co.</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Glen Burnie, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>Glen Burnie, Maryland</b> <b>35014</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>				d. STREET ADDRESS <b>3022 W. North Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>Mary</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-18-1889</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>St Mary's Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>							
13. FATHER'S NAME <b>Henry Cole</b>				14. MOTHER'S MAIDEN NAME <b>Lionel Cole</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Juanita Brown 2723 Parkwood Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paralysis agitans; osteo-arthritis fingers, old fracture r. femur</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 9,</b> 19 <b>59</b> , to <b>October 3,</b> 19 <b>59</b> that I last saw the deceased alive on <b>September 26,</b> 19 <b>59</b> and that death occurred at <b>9:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>400 N. Carrollton Avenue</b> DATE SIGNED <b>Oct. 5, 1959</b> ACTUAL SIGNATURE <b>James M. Pair</b> PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b> <b>Baltimore 23, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 8, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William A. Jackson Funeral Home Inc, Penna Ave.</b>				24a. REC'D BY REGISTRAR <b>916</b> <b>OCT 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlando J. Hume</b>	

100

• *Journal of Management Education* 24(10):1103-1114

0-49 0-50

• •

• 55 •

20

• • • • •

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10979

## CERTIFICATE OF DEATH

10935

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A. A.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>111 Hatton Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>FREDERICK</b> Last <b>HARMER</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>12,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12, 1896</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bell Tel. Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>N. J.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Harmer</b>		14. MOTHER'S MAIDEN NAME <b>Julia B. Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>164-05-9624</b>	
17. INFORMANT <b>Dr. Jene D. Trettin-111 Hatton Dr., Severna Pk.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary edema</b> (c) <b>Carcinoma of</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>72 hrs</b> <b>8 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 May</b> , 19 <b>59</b> , to <b>12 Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12 Oct</b> , 19 <b>59</b> , and that death occurred at <b>5:40 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jene D. Trettin</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>12 Oct 59</b>	
PHYSICIAN'S NAME (Type)		M.D. <b>111 HATTON DR. SEVERNA PARK, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>10/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Drexel Hill, Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Tucker &amp; Sons-Rock 17</b>		24. REC'D BY REGISTRAR DATE <b>OCT 13 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10936

10930

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>(n)</u> Last <u>HENDRICKS</u>				4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 May 1889</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John W. Ford</u>				14. MOTHER'S MAIDEN NAME <u>Annie F. Bull</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Annapolis, Odell J. Payseur 411 Jefferson St., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>12 October, 1959</u> , that I last saw the deceased alive on <u>11 October, 1959</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>R. C. Laning</u>				M.D. <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.</u> <u>10-12-59</u>			
PHYSICIAN'S NAME (Type) <u>R. C. LANING LCDR MC USN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEROF <u>10-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u> ADDRESS <u>Duke &amp; Gloucester</u>				24a. REC'D BY REGISTRAR <u>OCT 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. P. H.</u>	

CERTIFICATE OF DEATH

10030

<p>1. PLACE IN WHICH DECEASED WAS FOUND</p> <p>2. NAME OF DECEASED</p>		<p>3. SEX</p> <p>4. AGE</p>	
<p>5. OCCUPATION</p> <p>6. DATE OF DEATH</p>		<p>7. TIME OF DEATH</p> <p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p> <p>10. MANNER OF DEATH</p>		<p>11. SIGNATURE OF PHYSICIAN</p> <p>12. SIGNATURE OF DEATH REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESSES</p> <p>14. SIGNATURE OF DEATH REGISTRAR</p>		<p>15. SIGNATURE OF DEATH REGISTRAR</p> <p>16. SIGNATURE OF DEATH REGISTRAR</p>	
<p>17. SIGNATURE OF DEATH REGISTRAR</p> <p>18. SIGNATURE OF DEATH REGISTRAR</p>		<p>19. SIGNATURE OF DEATH REGISTRAR</p> <p>20. SIGNATURE OF DEATH REGISTRAR</p>	
<p>21. SIGNATURE OF DEATH REGISTRAR</p> <p>22. SIGNATURE OF DEATH REGISTRAR</p>		<p>23. SIGNATURE OF DEATH REGISTRAR</p> <p>24. SIGNATURE OF DEATH REGISTRAR</p>	
<p>25. SIGNATURE OF DEATH REGISTRAR</p> <p>26. SIGNATURE OF DEATH REGISTRAR</p>		<p>27. SIGNATURE OF DEATH REGISTRAR</p> <p>28. SIGNATURE OF DEATH REGISTRAR</p>	
<p>29. SIGNATURE OF DEATH REGISTRAR</p> <p>30. SIGNATURE OF DEATH REGISTRAR</p>		<p>31. SIGNATURE OF DEATH REGISTRAR</p> <p>32. SIGNATURE OF DEATH REGISTRAR</p>	
<p>33. SIGNATURE OF DEATH REGISTRAR</p> <p>34. SIGNATURE OF DEATH REGISTRAR</p>		<p>35. SIGNATURE OF DEATH REGISTRAR</p> <p>36. SIGNATURE OF DEATH REGISTRAR</p>	
<p>37. SIGNATURE OF DEATH REGISTRAR</p> <p>38. SIGNATURE OF DEATH REGISTRAR</p>		<p>39. SIGNATURE OF DEATH REGISTRAR</p> <p>40. SIGNATURE OF DEATH REGISTRAR</p>	
<p>41. SIGNATURE OF DEATH REGISTRAR</p> <p>42. SIGNATURE OF DEATH REGISTRAR</p>		<p>43. SIGNATURE OF DEATH REGISTRAR</p> <p>44. SIGNATURE OF DEATH REGISTRAR</p>	
<p>45. SIGNATURE OF DEATH REGISTRAR</p> <p>46. SIGNATURE OF DEATH REGISTRAR</p>		<p>47. SIGNATURE OF DEATH REGISTRAR</p> <p>48. SIGNATURE OF DEATH REGISTRAR</p>	
<p>49. SIGNATURE OF DEATH REGISTRAR</p> <p>50. SIGNATURE OF DEATH REGISTRAR</p>		<p>51. SIGNATURE OF DEATH REGISTRAR</p> <p>52. SIGNATURE OF DEATH REGISTRAR</p>	
<p>53. SIGNATURE OF DEATH REGISTRAR</p> <p>54. SIGNATURE OF DEATH REGISTRAR</p>		<p>55. SIGNATURE OF DEATH REGISTRAR</p> <p>56. SIGNATURE OF DEATH REGISTRAR</p>	
<p>57. SIGNATURE OF DEATH REGISTRAR</p> <p>58. SIGNATURE OF DEATH REGISTRAR</p>		<p>59. SIGNATURE OF DEATH REGISTRAR</p> <p>60. SIGNATURE OF DEATH REGISTRAR</p>	
<p>61. SIGNATURE OF DEATH REGISTRAR</p> <p>62. SIGNATURE OF DEATH REGISTRAR</p>		<p>63. SIGNATURE OF DEATH REGISTRAR</p> <p>64. SIGNATURE OF DEATH REGISTRAR</p>	
<p>65. SIGNATURE OF DEATH REGISTRAR</p> <p>66. SIGNATURE OF DEATH REGISTRAR</p>		<p>67. SIGNATURE OF DEATH REGISTRAR</p> <p>68. SIGNATURE OF DEATH REGISTRAR</p>	
<p>69. SIGNATURE OF DEATH REGISTRAR</p> <p>70. SIGNATURE OF DEATH REGISTRAR</p>		<p>71. SIGNATURE OF DEATH REGISTRAR</p> <p>72. SIGNATURE OF DEATH REGISTRAR</p>	
<p>73. SIGNATURE OF DEATH REGISTRAR</p> <p>74. SIGNATURE OF DEATH REGISTRAR</p>		<p>75. SIGNATURE OF DEATH REGISTRAR</p> <p>76. SIGNATURE OF DEATH REGISTRAR</p>	
<p>77. SIGNATURE OF DEATH REGISTRAR</p> <p>78. SIGNATURE OF DEATH REGISTRAR</p>		<p>79. SIGNATURE OF DEATH REGISTRAR</p> <p>80. SIGNATURE OF DEATH REGISTRAR</p>	
<p>81. SIGNATURE OF DEATH REGISTRAR</p> <p>82. SIGNATURE OF DEATH REGISTRAR</p>		<p>83. SIGNATURE OF DEATH REGISTRAR</p> <p>84. SIGNATURE OF DEATH REGISTRAR</p>	
<p>85. SIGNATURE OF DEATH REGISTRAR</p> <p>86. SIGNATURE OF DEATH REGISTRAR</p>		<p>87. SIGNATURE OF DEATH REGISTRAR</p> <p>88. SIGNATURE OF DEATH REGISTRAR</p>	
<p>89. SIGNATURE OF DEATH REGISTRAR</p> <p>90. SIGNATURE OF DEATH REGISTRAR</p>		<p>91. SIGNATURE OF DEATH REGISTRAR</p> <p>92. SIGNATURE OF DEATH REGISTRAR</p>	
<p>93. SIGNATURE OF DEATH REGISTRAR</p> <p>94. SIGNATURE OF DEATH REGISTRAR</p>		<p>95. SIGNATURE OF DEATH REGISTRAR</p> <p>96. SIGNATURE OF DEATH REGISTRAR</p>	
<p>97. SIGNATURE OF DEATH REGISTRAR</p> <p>98. SIGNATURE OF DEATH REGISTRAR</p>		<p>99. SIGNATURE OF DEATH REGISTRAR</p> <p>100. SIGNATURE OF DEATH REGISTRAR</p>	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10937

10931

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>2 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Unnamed</u> Middle <u>HOCKENBERRY</u> Last <u>HOCKENBERRY</u>		4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 29, 1959</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Owen HOCKENBERRY</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Jean POWERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordic respiratory failure</u> 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Premature labor &amp; delivery</u> DUE TO (c) <u>Premature Separation low in placenta</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 29, 19 59</u> , to <u>Oct. 30, 19 59</u> , that I last saw the deceased alive on <u>Oct. 30, 1959</u> , and that death occurred at <u>1:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stuart M. Christhilf</u>		ADDRESS (Street, city or town, state) <u>69 Franklin St., Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Stuart M. Christhilf</u>		DATE SIGNED <u>10/30/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cem., Annapolis, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 4 '59</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2063324XVI

1893

1893

CERTIFICATE OF DEATH

IN THE COUNTY OF ... STATE OF ...  
I, the undersigned, a duly qualified and licensed ...  
do hereby certify that on the ... day of ...  
at the place named above, died ...  
aged ... years ...  
cause of death ...  
Signature of ...  
Witness ...

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10938

10932

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>HOWARD</b> Last <b>HOWARD</b>		4. DATE OF DEATH Month <b>October</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-1920</b>
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>39</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Howard</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Moreland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-18-5873</b>	
17. INFORMANT <b>Richard Howard</b>		Address <b>Gambrells Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>600.0 Suffered from Pneumonia</b> DUE TO (b) <b>Secondary Hematogenous</b> DUE TO (c) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 17, 1959</b> , to <b>Oct 18, 1959</b> , that I last saw the deceased alive on <b>Oct 18, 1959</b> , and that death occurred at <b>12:35 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. L. Richardson</b>		ADDRESS (Street, city or town, state) <b>110 Clay St., Annapolis, Md.</b>	
PHYSICIAN'S NAME (Type) <b>R. L. Richardson</b>		DATE SIGNED <b>10/17/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-21-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wilson Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Gambrells Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Beesett</b>		24a. REC'D BY REGISTRAR <b>OCT 23 '59</b>	
ADDRESS <b>108 Wash St. Annapolis Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933

1933

1933

STATE OF NEW YORK

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of death: *Jan 15 1933*  
5. Place of death: *New York City*  
6. Cause of death: *Heart Disease*  
7. Signature of physician: *Dr. J. Smith*  
8. Signature of registrar: *John Doe*  
9. Date of registration: *Jan 16 1933*



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10980**  
**CERTIFICATE OF DEATH**

10939  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>			c. LENGTH OF STAY IN 1b <u>10mo. 14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>2212.2</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>219 E. Church</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Saunders</u> Middle Last <u>Hutt</u>				4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/13/1882</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hutt</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Bishop</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Nephrosclerosis</u> DUE TO (c) <u>Generalized and Cerebral Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Cerebral Arteriosclerosis-Inguinal Hernia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour <u>9.00</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not-white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/14</u> , 19 <u>58</u> , to <u>10/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/18</u> , 19 <u>59</u> , and that death occurred at <u>11:05</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp, M.D.</u>		M.D.		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u>		DATE SIGNED <u>10/19/59</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>				ADDRESS <u>Crownsville State Hospital, Md.</u>		DATE <u>10/19/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green acres</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Starnes</u>		ADDRESS <u>Salisbury Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10380

10380

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BIRMINGHAM 10

IMMEDIATE

Blank form with horizontal lines for text entry.

## CERTIFICATE OF DEATH

Reg. Dist. No.

10933

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>13 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>817 Spa Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>Ireland</u> Last <u>Irland</u>				4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 3 - 1875</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>6</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>—</u>				13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>Sallie McGOWANS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT Address <u>Pearletta-Johnson - 817 Spa Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>awc glomerulonephritis</u> 590x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-26-59</u> , 19 <u>59</u> , to <u>10-6-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-4-59</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>62 Orchard St</u> DATE SIGNED <u>10-6-59</u>			
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>				M.D. <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer-Hill</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u> ADDRESS <u>ANNAPOLIS - Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

10933-10-11-59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



## CERTIFICATE OF DEATH

Reg. Dist. No.

10941

10981

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>				c. LENGTH OF STAY IN 1b <i>10 weeks</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phys. Manor Nursing Home</i>				d. STREET ADDRESS <i>FRANKIE Branch &amp; Co Ad-</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>H. L.</i> Last <i>Jackson</i>				4. DATE OF DEATH Month <i>10</i> Day <i>10</i> Year <i>1959</i>			
5. SEX <i>M.</i>		6. COLOR OR RACE <i>C.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 18 1871</i>	
9. AGE (In years last birthday) <i>85</i>		IF UNDER 1 YEAR Months <i>10</i> Days <i>10</i>		IF UNDER 24 HRS. Hours <i>10</i> Min. <i>10</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk Stone</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>no</i>			
11. BIRTH PLACE (State or foreign country) <i>U.S.A. (Virginia)</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
13. FATHER'S NAME <i>Robert L. Jackson</i>				14. MOTHER'S MAIDEN NAME <i>India Collins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>no</i>			
17. INFORMANT <i>Gladys Jackson Hawkins</i>				Address <i>1032 Druid Hill Baltimore</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>peripheral thrombosis -</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerotic cardio-</i> DUE TO <i>vascular disease &amp; heart failure</i> (c) <i>no</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>7/18</i> , 19 <i>57</i> , to <i>10/10</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>10/9</i> , 19 <i>59</i> , and that death occurred at <i>12:50</i> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Felix Freuler</i>				ADDRESS (Street, city or town, state) <i>P.O. Box 97 Odenton</i>			
PHYSICIAN'S NAME (Type) <i>Felix Freuler</i>				DATE SIGNED <i>10/10/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE, THEREOF <i>10/11/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Blue Bell, W.D.</i>		22d. LOCATION (City, town, or county) (State) <i>Oak Grove</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLAND FUNERAL HOME</i>				ADDRESS <i>1716</i>			
24a. REC'D BY REGISTRAR <i>DATE OCT 13 '59</i>				24b. REGISTRAR'S SIGNATURE <i>Carlton E. Jones</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. PLACE OF DEATH COUNTY		2. FULL ADDRESS - (Include street, city, state, and zip code)	
3. DATE OF DEATH		4. TIME OF DEATH	
5. NAME OF DECEASED		6. SEX	
7. AGE		8. RACE	
9. MARITAL STATUS		10. OCCUPATION	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR	
15. SIGNATURE OF WITNESSES		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CLERK		22. SIGNATURE OF ASSISTANT CLERK	
23. SIGNATURE OF DEPUTY CLERK		24. SIGNATURE OF RECORDS CLERK	
25. SIGNATURE OF CHIEF CLERK		26. SIGNATURE OF ASSISTANT CHIEF CLERK	
27. SIGNATURE OF DEPUTY CHIEF CLERK		28. SIGNATURE OF RECORDS ASSISTANT	
29. SIGNATURE OF CLERK		30. SIGNATURE OF ASSISTANT CLERK	
31. SIGNATURE OF DEPUTY CLERK		32. SIGNATURE OF RECORDS CLERK	
33. SIGNATURE OF CHIEF CLERK		34. SIGNATURE OF ASSISTANT CHIEF CLERK	
35. SIGNATURE OF DEPUTY CHIEF CLERK		36. SIGNATURE OF RECORDS CLERK	
37. SIGNATURE OF CLERK		38. SIGNATURE OF ASSISTANT CLERK	
39. SIGNATURE OF DEPUTY CLERK		40. SIGNATURE OF RECORDS CLERK	
41. SIGNATURE OF CHIEF CLERK		42. SIGNATURE OF ASSISTANT CHIEF CLERK	
43. SIGNATURE OF DEPUTY CHIEF CLERK		44. SIGNATURE OF RECORDS CLERK	
45. SIGNATURE OF CLERK		46. SIGNATURE OF ASSISTANT CLERK	
47. SIGNATURE OF DEPUTY CLERK		48. SIGNATURE OF RECORDS CLERK	
49. SIGNATURE OF CHIEF CLERK		50. SIGNATURE OF ASSISTANT CHIEF CLERK	
51. SIGNATURE OF DEPUTY CHIEF CLERK		52. SIGNATURE OF RECORDS CLERK	
53. SIGNATURE OF CLERK		54. SIGNATURE OF ASSISTANT CLERK	
55. SIGNATURE OF DEPUTY CLERK		56. SIGNATURE OF RECORDS CLERK	
57. SIGNATURE OF CHIEF CLERK		58. SIGNATURE OF ASSISTANT CHIEF CLERK	
59. SIGNATURE OF DEPUTY CHIEF CLERK		60. SIGNATURE OF RECORDS CLERK	
61. SIGNATURE OF CLERK		62. SIGNATURE OF ASSISTANT CLERK	
63. SIGNATURE OF DEPUTY CLERK		64. SIGNATURE OF RECORDS CLERK	
65. SIGNATURE OF CHIEF CLERK		66. SIGNATURE OF ASSISTANT CHIEF CLERK	
67. SIGNATURE OF DEPUTY CHIEF CLERK		68. SIGNATURE OF RECORDS CLERK	
69. SIGNATURE OF CLERK		70. SIGNATURE OF ASSISTANT CLERK	
71. SIGNATURE OF DEPUTY CLERK		72. SIGNATURE OF RECORDS CLERK	
73. SIGNATURE OF CHIEF CLERK		74. SIGNATURE OF ASSISTANT CHIEF CLERK	
75. SIGNATURE OF DEPUTY CHIEF CLERK		76. SIGNATURE OF RECORDS CLERK	
77. SIGNATURE OF CLERK		78. SIGNATURE OF ASSISTANT CLERK	
79. SIGNATURE OF DEPUTY CLERK		80. SIGNATURE OF RECORDS CLERK	
81. SIGNATURE OF CHIEF CLERK		82. SIGNATURE OF ASSISTANT CHIEF CLERK	
83. SIGNATURE OF DEPUTY CHIEF CLERK		84. SIGNATURE OF RECORDS CLERK	
85. SIGNATURE OF CLERK		86. SIGNATURE OF ASSISTANT CLERK	
87. SIGNATURE OF DEPUTY CLERK		88. SIGNATURE OF RECORDS CLERK	
89. SIGNATURE OF CHIEF CLERK		90. SIGNATURE OF ASSISTANT CHIEF CLERK	
91. SIGNATURE OF DEPUTY CHIEF CLERK		92. SIGNATURE OF RECORDS CLERK	
93. SIGNATURE OF CLERK		94. SIGNATURE OF ASSISTANT CLERK	
95. SIGNATURE OF DEPUTY CLERK		96. SIGNATURE OF RECORDS CLERK	
97. SIGNATURE OF CHIEF CLERK		98. SIGNATURE OF ASSISTANT CHIEF CLERK	
99. SIGNATURE OF DEPUTY CHIEF CLERK		100. SIGNATURE OF RECORDS CLERK	

11

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 1-101, SECTION 1-101.01, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 1-101, SECTION 1-101.02.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10942

10934

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Ad. County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>Cumprstone Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Anne Arundel General Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Baby</b>		4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 22, 1959</b>
9. AGE (In years lost birthday) yrs. <b>20</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Richard Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Alice Marie Edwards</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mother Cumprstone, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral birth injury</b> 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Asphyxia consequent to maternal hemorrhage</b> DUE TO (c) <b>Immediate</b> INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None other</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>22 Oct</b> , 19 <b>59</b> , to <b>22 Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>22 Oct</b> , 19 <b>59</b> , and that death occurred at <b>8:41 P.</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>J. H. Walker</b> ADDRESS (Street, city or town, state) <b>121 Cathedral St Annapolis</b> DATE SIGNED <b>23 Oct 59</b> PHYSICIAN'S NAME (Type) <b>M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese #108 Wash St. Annapolis</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

2063299XU5

CONFIDENTIAL

10034

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10943

## CERTIFICATE OF DEATH

Reg. Dist. No.

10935

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>		d. STREET ADDRESS <b>34 Pinkney St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		3. NAME OF DECEASED (Type or print) First <b>Adella</b>		Middle <b>JOHNSON</b>		Last <b>JOHNSON</b>	
4. DATE OF DEATH Month <b>October</b>		Day <b>16</b>		Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 18, 1908</b>	
9. AGE (In years lost birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months <b>51</b>		11. IF UNDER 24 HRS. Days <b>51</b>		12. IF UNDER 24 HRS. Hours <b>51</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Actwood</b>		14. MOTHER'S MAIDEN NAME <b>Florence Colbert</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 13</b> , 19 <b>59</b> , to <b>Oct 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 16</b> , 19 <b>59</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>37 Calvert St.,</b>		DATE SIGNED <b>THEODORE H. JOHNSON M.D.</b>			
ACTUAL SIGNATURE <b>THEODORE H. JOHNSON M.D.</b>		PHYSICIAN'S NAME (Type) <b>T. H. JOHNSON</b>		Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-19-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hall</b>		22d. LOCATION (City, town, or county) <b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese #108 Wash St Annapolis Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>			

10333

CERTIFICATE OF DEATH

10333

10333

10333

10333

10333

10333

10333

10333

10333

10333

10333

10333

10333

10333

10333

10333

10333

1

10982

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>a a</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>090 Lanns Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>James Johnson</i>		4. DATE OF DEATH <i>10/5/59</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 14<sup>th</sup> 1892</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <i>Ret. U. S. M.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Boilermaker Ret.</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Slavin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>Wald W. I</i>	
17. CAUSE OF DEATH [Enter only one cause per box for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Arteriosclerosis</i> DUE TO (b) <i>Rheumatoid arthritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9/30/59</i> to <i>10/5/59</i> , that I last saw the deceased alive on <i>10/3/59</i> , 19 <i>59</i> , and that death occurred at <i>1145 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph Hipsley</i> M.D.		ADDRESS (Street, city or town, state) <i>10/5/59</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH HIPSLEY</i>		DATE SIGNED <i>10/5/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 8-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i> ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 9 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Carlin E. Hines</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10381

CERTIFICATE OF DEATH

10382

Wife

Wife

Wife

Married at

Married at

at

at

at

at

at

at

at

at

at

at

at

at

at

at

at

at

at

at

at

at

at



10936

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sylvester</u> Middle <u>JOHNSON</u> Last <u>JOHNSON</u>				4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/21</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months <u>38</u> Days <u>38</u> Hours <u>38</u> Min. <u>38</u>	IF UNDER 24 HRS. Hours <u>38</u> Min. <u>38</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer- Gardener</u>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Perry Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Susie Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>1/13/43-7/30/43 Unknown</u>		INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia Terminal</u> <u>134.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Meningitis (Cryptococcosis)</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) (County) (State) -----							
21. I certify that I attended the deceased from <u>9/24</u> , 19 <u>59</u> , to <u>10/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/21</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md.</u>				DATE SIGNED <u>10/21/59</u>			
ACTUAL SIGNATURE <u>Hildegard Heard Reissman</u>							
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-26-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George E. Nelson</u>				ADDRESS <u>1348 W. Calhoun St</u>		24a. REG'D BY REGISTRAR <u>Oct 26 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Lawrence  
(212 0000 0794)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home or, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1966</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. General Hospital</u>		d. STREET ADDRESS <u>1966 West Street</u>	
3. NAME OF DECEASED (Type or print) <u>Alphonsa</u> First <u>Jones</u> Middle Last		4. DATE OF DEATH <u>10 - 19</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	10c. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>Willie Jones</u>		14. MOTHER'S MAIDEN NAME <u>Roberta A. Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1966 West Street</u>	
17. INFORMANT <u>Roberta A. Lee</u>		Address <u>1966 West Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10/19/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-22-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u>		24a. REC'D BY REGISTRAR <u>23 '59</u>	
ADDRESS <u>#108 Wash St. Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

2063162XV2

11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John Doe

2. Age: 45 Sex: Male

3. Date of Death: Jan 15, 1920 Time: 10:00 AM

4. Place of Death: Home

5. Cause of Death: Myocardial Infarction

6. Immediate Cause: Coronary Thrombosis

7. Contributing Causes: None

8. Manner of Death: Natural

9. Signature of Examiner: [Signature]

10. Date of Certificate: Jan 16, 1920

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10947

Reg. Dist. No.

10983

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 11</u> <u>3 V01-4</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Moose Hall, S. Cain Highway</u>				d. STREET ADDRESS <u>1016 W. 38th Street,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Brice</u> <u>A. Keys</u>				4. DATE OF DEATH <u>October 25th</u> <u>19 59</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/2/13</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance man at Eastern Box Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James W. Keys</u>				14. MOTHER'S MAIDEN NAME <u>Florence Stambaugh.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mr. Leroy L. Keys (brother)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/25/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ponlar</u>		22d. LOCATION (City, town, or county) <u>Balto Co. Md.</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Donovan - 3818 Roland Ave</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## CERTIFICATE OF DEATH

Reg. Dist. No. 10948

10938

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>10</b> <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. STREET ADDRESS <b>506 Pafel Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>SKINNER</b> Last <b>KOLBE</b>				4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 2, 1901</b>	9. AGE (In years lost birthday) yrs. <b>58</b>	IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.	IF UNDER 24 HRS. Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>HENRY T. MILLER</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA E. BOUSH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>—</b>		INFORMANT <b>MRS. ERNEST W. ROBY</b>		Address <b>#2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute pulmonary edema</b> <b>422.1</b> DUE TO (b) <b>arteriosclerosis C.V.D.</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>— 19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>		
21. I certify that I attended the deceased from <b>Oct. 3, 1959</b> , to <b>Oct. 3, 1959</b> , that I last saw the deceased alive on <b>Oct. 3, 1959</b> , and that death occurred at <b>1:40 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank M. Shipley</b>		M.D. <b>121 Cathedral St.,</b>		DATE SIGNED <b>10/5/59</b>			
PHYSICIAN'S NAME (Type) <b>Frank M. Shipley</b>		Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10-6-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF</b>		22d. LOCATION (City, town, or county) <b>Annapolis Md.</b>		(State) <b>MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. G. &amp; Sons</b>		ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kline</b>		

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

10048

ATTESTATION OF DEATH

2003

Alma (Armed)

Barryland

Alma (Armed)

Alma (Armed)

Alma (Armed)

Alma (Armed)

10048

October 3, 1903

October 3, 1903

October 3, 1903

October 3, 1903

28

October 3, 1903

October 3, 1903

October 3, 1903

U.S.

Alma (Armed)

Alma (Armed)

Alma (Armed)

Alma (Armed)

1

#2

Alma (Armed)

Alma (Armed)

Alma (Armed)

Alma (Armed)

Oct. 3, 1903

Oct. 3, 1903

Oct. 3, 1903

10048

Alma (Armed)

Alma (Armed)

10048

Alma (Armed)

Alma (Armed)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10949

10984

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundle</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garland Park Ferndale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>103 Elm Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>M.</u> Last <u>Krieger</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles E. Vettters</u>		14. MOTHER'S MAIDEN NAME <u>Ida V. Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Wm. Frederick Krieger-Son-Balto. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>accident thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>the advancement of the heart &amp; arteriosclerosis</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1954</u> , to <u>10-31</u> , 1959, that I last saw the deceased alive on <u>10-31</u> , 1959, and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene Schnitzer</u>		ADDRESS (Street, city or town, state) <u>D-3904 S. Hanover St. Md.</u>	
DATE SIGNED <u>11-2-59</u>			
PHYSICIAN'S NAME (Type) <u>Eugene Schnitzer, M.D.</u>		<u>Baltimore 25, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 3, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Highway Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>KRAUSE FUNERAL HOME</u>		ADDRESS <u>1216 S. Charles St.</u>	
24a. REC'D BY REGISTRAR <u>DATE NOV 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

10-13

CERTIFICATE OF DEATH

1924

1. NAME OF DECEASED J. J. JONES		2. SEX Male		3. AGE 45		4. DATE OF DEATH Jan 15 1924		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease		7. PLACE OF BIRTH New York		8. OCCUPATION Farmer		9. MARITAL STATUS Married		10. EDUCATION High School		11. RELIGION Protestant		12. COLOR White		13. NATIONALITY American		14. PLACE OF DEATH Home		15. CAUSE OF DEATH Heart Disease		16. PLACE OF BIRTH New York		17. OCCUPATION Farmer		18. MARITAL STATUS Married		19. EDUCATION High School		20. RELIGION Protestant		21. COLOR White		22. NATIONALITY American	
23. NAME OF DECEASED J. J. JONES		24. SEX Male		25. AGE 45		26. DATE OF DEATH Jan 15 1924		27. PLACE OF DEATH Home		28. CAUSE OF DEATH Heart Disease		29. PLACE OF BIRTH New York		30. OCCUPATION Farmer		31. MARITAL STATUS Married		32. EDUCATION High School		33. RELIGION Protestant		34. COLOR White		35. NATIONALITY American		36. PLACE OF DEATH Home		37. CAUSE OF DEATH Heart Disease		38. PLACE OF BIRTH New York		39. OCCUPATION Farmer		40. MARITAL STATUS Married		41. EDUCATION High School		42. RELIGION Protestant		43. COLOR White		44. NATIONALITY American	

I hereby certify that the foregoing is a true and correct copy of the original record as the same appears in the files of the State Department of Health.  
 WYOMING STATE DEPARTMENT OF HEALTH  
 BATHING 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10985

CERTIFICATE OF DEATH

Reg. Dist. No.

10950

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn (Rural)</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 2, Box 95</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Roberta</b> Last <b>Loving</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 13, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Clark</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Griffith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Ruth M. Loving</b> Address <b>Same as 2</b>	
17. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260 X Cardio-Vascular Disease</b> DUE TO (b) <b>Arterio-Sclerosis + Hypertension</b> DUE TO (c) <b>Dilated</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5-6 yrs</b> <b>20 yrs</b> <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/21/59</b> to <b>10/21/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/21/59</b> , 19 <b>59</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chas. L. Ball Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>203 W. Maple Rd.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Chas. L. Ball Jr.</b>		<b>Linthicum Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 24, 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Anne Arundel, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping &amp; Kirkley, Glen Burnie, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>OCT 23 '59</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

10050

CERTIFICATE OF TITLE

1988

1



# 10986 10951 10-27-59 et CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TARGET 11</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hambrills</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hambrills Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>CLAY</u> Last <u>Lowery</u>				4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 March 1874</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Tilghman - md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Lowery</u>				14. MOTHER'S MAIDEN NAME <u>Alice Corington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>UNKNOWN</u>		17. INFORMANT <u>Mr. Walter Lowery</u> Address <u>108 5th Ave. Bklyn, N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchial Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> 19 <u>56</u> , to <u>Oct</u> 19 <u>57</u> , that I last saw the deceased alive on <u>October 13</u> , 19 <u>57</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C.B. McDonald M.D.</u>				ADDRESS (Street, city or town, state) <u>P.O. Box 515</u>		DATE SIGNED <u>10-16-59</u>	
PHYSICIAN'S NAME (Type) <u>Eden Burnie md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>15 Oct 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tilghman Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tilghman md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware - Eden Burnie</u>				24a. REC'D BY REGISTRAR <u>  </u> ADDRESS <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
				DATE <u>OCT 22 '59</u>			

CERTIFICATE OF DEATH

10986

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. RACE</p>	
<p>5. DATE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. PLACE OF BIRTH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. OCCUPATION</p>		<p>10. CAUSE OF DEATH</p>	
<p>11. MEDICAL HISTORY</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESSES</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF NEXT OF KIN</p>	
<p>17. SIGNATURE OF BURIAL OFFICIAL</p>		<p>18. SIGNATURE OF CHURCH OFFICIAL</p>	
<p>19. SIGNATURE OF FUNERAL HOME</p>		<p>20. SIGNATURE OF CEMETERY</p>	
<p>21. SIGNATURE OF HEALTH DEPARTMENT</p>		<p>22. SIGNATURE OF COUNTY CLERK</p>	
<p>23. SIGNATURE OF CITY CLERK</p>		<p>24. SIGNATURE OF STATE CLERK</p>	
<p>25. SIGNATURE OF VICE CLERK</p>		<p>26. SIGNATURE OF ASSISTANT CLERK</p>	
<p>27. SIGNATURE OF DEPUTY CLERK</p>		<p>28. SIGNATURE OF CLERK</p>	
<p>29. SIGNATURE OF CLERK</p>		<p>30. SIGNATURE OF CLERK</p>	
<p>31. SIGNATURE OF CLERK</p>		<p>32. SIGNATURE OF CLERK</p>	
<p>33. SIGNATURE OF CLERK</p>		<p>34. SIGNATURE OF CLERK</p>	
<p>35. SIGNATURE OF CLERK</p>		<p>36. SIGNATURE OF CLERK</p>	
<p>37. SIGNATURE OF CLERK</p>		<p>38. SIGNATURE OF CLERK</p>	
<p>39. SIGNATURE OF CLERK</p>		<p>40. SIGNATURE OF CLERK</p>	
<p>41. SIGNATURE OF CLERK</p>		<p>42. SIGNATURE OF CLERK</p>	
<p>43. SIGNATURE OF CLERK</p>		<p>44. SIGNATURE OF CLERK</p>	
<p>45. SIGNATURE OF CLERK</p>		<p>46. SIGNATURE OF CLERK</p>	
<p>47. SIGNATURE OF CLERK</p>		<p>48. SIGNATURE OF CLERK</p>	
<p>49. SIGNATURE OF CLERK</p>		<p>50. SIGNATURE OF CLERK</p>	
<p>51. SIGNATURE OF CLERK</p>		<p>52. SIGNATURE OF CLERK</p>	
<p>53. SIGNATURE OF CLERK</p>		<p>54. SIGNATURE OF CLERK</p>	
<p>55. SIGNATURE OF CLERK</p>		<p>56. SIGNATURE OF CLERK</p>	
<p>57. SIGNATURE OF CLERK</p>		<p>58. SIGNATURE OF CLERK</p>	
<p>59. SIGNATURE OF CLERK</p>		<p>60. SIGNATURE OF CLERK</p>	
<p>61. SIGNATURE OF CLERK</p>		<p>62. SIGNATURE OF CLERK</p>	
<p>63. SIGNATURE OF CLERK</p>		<p>64. SIGNATURE OF CLERK</p>	
<p>65. SIGNATURE OF CLERK</p>		<p>66. SIGNATURE OF CLERK</p>	
<p>67. SIGNATURE OF CLERK</p>		<p>68. SIGNATURE OF CLERK</p>	
<p>69. SIGNATURE OF CLERK</p>		<p>70. SIGNATURE OF CLERK</p>	
<p>71. SIGNATURE OF CLERK</p>		<p>72. SIGNATURE OF CLERK</p>	
<p>73. SIGNATURE OF CLERK</p>		<p>74. SIGNATURE OF CLERK</p>	
<p>75. SIGNATURE OF CLERK</p>		<p>76. SIGNATURE OF CLERK</p>	
<p>77. SIGNATURE OF CLERK</p>		<p>78. SIGNATURE OF CLERK</p>	
<p>79. SIGNATURE OF CLERK</p>		<p>80. SIGNATURE OF CLERK</p>	
<p>81. SIGNATURE OF CLERK</p>		<p>82. SIGNATURE OF CLERK</p>	
<p>83. SIGNATURE OF CLERK</p>		<p>84. SIGNATURE OF CLERK</p>	
<p>85. SIGNATURE OF CLERK</p>		<p>86. SIGNATURE OF CLERK</p>	
<p>87. SIGNATURE OF CLERK</p>		<p>88. SIGNATURE OF CLERK</p>	
<p>89. SIGNATURE OF CLERK</p>		<p>90. SIGNATURE OF CLERK</p>	
<p>91. SIGNATURE OF CLERK</p>		<p>92. SIGNATURE OF CLERK</p>	
<p>93. SIGNATURE OF CLERK</p>		<p>94. SIGNATURE OF CLERK</p>	
<p>95. SIGNATURE OF CLERK</p>		<p>96. SIGNATURE OF CLERK</p>	
<p>97. SIGNATURE OF CLERK</p>		<p>98. SIGNATURE OF CLERK</p>	
<p>99. SIGNATURE OF CLERK</p>		<p>100. SIGNATURE OF CLERK</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10987

CERTIFICATE OF DEATH

Reg. Dist. No.

10

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mc</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood Forest</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood Forest</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>MACDONALD</u> Last		4. DATE OF DEATH Month <u>OCT</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 24 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STANLEY PRZYBYLOWSKI</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Willow Macdonald # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 WKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 OCT</u> , 19 <u>59</u> , to <u>23 OCT</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>23 OCT</u> , 19 <u>59</u> , and that death occurred at <u>8:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u>		ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis Md.</u>		DATE SIGNED <u>10/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>OCT 27 1959</u>		22b. NAME OF CEMETERY OR CREMATORY <u>OAKLAND CEM.</u>	
22c. LOCATION (City, town, or county) (State) <u>PHILADELPHIA PA.</u>		22d. REC'D BY REGISTRAR DATE <u>OCT 27 '59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

CERTIFICATE OF DEATH

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

10939

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. d. STREET ADDRESS <b>161 Green St.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ada</b>		First <b>Ada</b>		Middle <b>Lee</b>		Last <b>MACE</b>	
4. DATE OF DEATH <b>October</b>		Month <b>October</b>		Day <b>27</b>		Year <b>1959</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 13, 1884</b>	
9. AGE (In years lost birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WASHINGTON A MARCHANT</b>				14. MOTHER'S MAIDEN NAME <b>ADA A LYON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>CHARLES B. MACE</b>		Address <b>(2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple emboluscular emboli</b> <b>433.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Endocardial thrombi + auricular fibrillation</b> DUE TO (c) <b>5 yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>55</b> , to <b>Oct</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct 26</b> , 19 <b>59</b> , and that death occurred at <b>5:15 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John Hedeman</b>				ADDRESS (Street, city or town, state) <b>121 Cathedral St.,</b>		DATE SIGNED <b>10/27/59</b>	
PHYSICIAN'S NAME (Type) <b>John Hedeman</b>				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 29-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Annes Cent</b>		22d. LOCATION (City, town, or county) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Doyle Sons</b>				ADDRESS <b>Annapolis Md</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 29 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Farris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10038

10038

1. Name of deceased	2. Sex	3. Age	4. Date of death
5. Place of death	6. Cause of death	7. Signature of physician	8. Signature of registrar
9. Remarks			



10954

## CERTIFICATE OF DEATH

10940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Campbell</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>U.S. General</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lynchburg</i> 83X-3	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Boyd</i> Middle <i>Lawrence</i> Last <i>Maddox</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>19</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2-1881</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cabinet Maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cabinet Maker</i>	
11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>James Maddox</i>		14. MOTHER'S MAIDEN NAME <i>Martha Clark</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Arie C. Maddox</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-18-59</i> , to <i>10-19-59</i> , that I last saw the deceased alive on <i>10-19-59</i> , 19____, and that death occurred at <i>4 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Shipley</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>12 Cathedral St 10-19-59</i>	
PHYSICIAN'S NAME (Type) <i>Frank M. Shipley</i>		<i>Annapolis, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct 21-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Lynchburg Va</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>OCT 26 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10040

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1925</i>	
9. NAME OF SPOUSE <i>Jane Doe</i>		10. PLACE OF MARRIAGE <i>Baltimore, Md.</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. PLACE OF DEATH <i>Home</i>	
13. DATE OF DEATH <i>Dec 10 1945</i>		14. TIME OF DEATH <i>10:30 AM</i>	
15. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		16. SIGNATURE OF REGISTRAR <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

1

10988

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Michael Joseph Manning 528 Manor Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Michael Joseph</u> Middle <u>Manning</u> Last <u></u>				4. DATE OF DEATH Month <u>October</u> Day <u>24th</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/58</u>	9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Manning</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Cuddy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Mr. and Mrs. R. Manning (parents.)</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary infection</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Diarrhea</u> DUE TO (c) <u>Dehydration</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour o. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>10/21/59</u> , 19 <u></u> , to <u>10/24/59</u> , 19 <u></u> , that I last saw the deceased alive on <u>10/24/59</u> , 19 <u></u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. <u>Glen Burnie, Md.</u>		DATE SIGNED <u>10/25/59</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 27, 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping &amp; Kirkley</u>			ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u></u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>OCT 28 '59</u>							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

OFFICE OF DEATH

10088

Form with multiple lines for text entry, including fields for name, date, and other details. The text is mostly illegible due to the quality of the scan.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10989 Items 8 & 9 Film G-251 10/30/59.cac

### CERTIFICATE OF DEATH

10956

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>AA</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AD</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			c. LENGTH OF STAY IN 1b <u>720</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sunset Beach - Pasadena</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8418 RUGBY RD</u>				d. STREET ADDRESS <u>1 8418 RUGBY RD</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Enid</u> Middle <u>MASTERS</u> Last <u>MASTERS</u>				<b>4. DATE OF DEATH</b> Month <u>10</u> - Day <u>18</u> Year <u>1959</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1915</u> <u>12-14-14</u>		9. AGE (In years last birthday) <u>43 1/4</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>14</u> Hours <u>14</u> Min. <u>4</u> IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>OWEN Williams</u>					14. MOTHER'S MAIDEN NAME <u>Mary —</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Family</u> Address <u>Same</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>174X Carcinoma Brain (Metastatic)</u> DUE TO (b) <u>Carcinoma Uterus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/17</u> , 19 <u>59</u> , to <u>10/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/17</u> , 19 <u>59</u> , and that death occurred at <u>12 15</u> A.M., from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.					ADDRESS (Street, city or town, state) <u>3471 FT. SMALLWOOD ROAD</u> DATE SIGNED <u>10/19/59</u>						
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>					<u>PASADENA, MARYLAND</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>10-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem</u>			22d. LOCATION (City, town, or county) (State) <u>Brooklyn, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home 130 E. Fort Ave</u>					ADDRESS <u>Fort Ave</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.



10990

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>P.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>5 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GLEN BURNIE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>311 GLENWOOD AVE</u>				d. STREET ADDRESS <u>311 GLENWOOD AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Mary Miksunas</u>				4. DATE OF DEATH Month Day Year <u>10 22 19 59</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 26 - 1878</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILORS.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>LITHUANIA.</u> ✓	
13. FATHER'S NAME <u>VINCAS MIKSAVNAS</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MARIE HOFFMAN 311 GLENWOOD AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 19 59</u> to <u>OCTOBER 19 59</u> , that I last saw the deceased alive on <u>10-21-59</u> , 19 <u>59</u> , and that death occurred at <u>5:25 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C.R. MacDonald MD</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>204 Cream Hill 10-22-59.</u>			
PHYSICIAN'S NAME (Type) <u>C.R. MacDonald</u>				<u>Glen Burnie, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT-26, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOST HOLY REDEEMER</u>		22d. LOCATION (City, town, or county) (State) <u>BELAIR RD MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Jacobson</u>				ADDRESS <u>637 West Blvd</u>		24a. REC'D BY REGISTRAR <u>OCT 26 59</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12150

10941

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lothian</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		/d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>UNNAMED</b> Middle Last <b>Moreland</b>		4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 9, 1959</b>
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>3</b> Hours <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Clifton MORELAND</b>		14. MOTHER'S MAIDEN NAME <b>Esther Doreather MORELAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Prematurity</b> (c) <b>Prematurity</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 9, 1959</b> to <b>Nov. 10, 1959</b> , that I last saw the deceased alive on <b>Nov. 10, 1959</b> , and that death occurred at <b>8:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>62 Cathedral St., Annapolis, Maryland</b> DATE SIGNED <b>11/11/59</b>			
ACTUAL SIGNATURE <b>G. T. Allen</b>		M.D. <b>62 Cathedral St., Annapolis, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>A. T. Allen</b>		Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-11-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Lothian, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 17 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>	

2063226XVI

13:20  
3  
CERTIFICATE OF DEATH

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

13:20

10970  
See #3  
M  
0/0  
I  
0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10991

## CERTIFICATE OF DEATH

Reg. Dist. No.

10958

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>9yr. 13 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>804 W. Saratoga Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Morrow</b> Last <b>Morrow</b>		4. DATE OF DEATH Month <b>10</b> Day <b>10</b> Year <b>19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1898?</b>		9. AGE (In years last birthday) <b>61?</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>19</b> Min. <b>59</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>				11. BIRTHPLACE (State or foreign country) <b>Unknown</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, secondary to aortic insufficiency</b> <b>023X</b> DUE TO <b>Syphilis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dementia</b>												INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>															
20c. TIME OF INJURY Month, Day, Year Hour <b>2</b> m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>				20f. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>							
21. I certify that I attended the deceased from <b>9/27</b> , 19 <b>50</b> , to <b>10/10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/10</b> , 19 <b>59</b> , and that death occurred at <b>10:35</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>-----</b> DATE SIGNED ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b> M.D. <b>Crownsville State Hospital, Md. 10/13/59</b> PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md. 10/13/59</b>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>10-14-59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Mount Vernon</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Opm Reissman</b>				ADDRESS <b>-----</b>				24a. REC'D BY REGISTRAR <b>10-14-59</b>				24b. REGISTRAR'S SIGNATURE <b>-----</b>							

OCT 21 '59





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10959

10992

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY OR TOWN <u>Shady Side, Md.</u>		CITY OR TOWN <u>Shady Side, Md.</u>	
CITY OR TOWN <u>Shady Side</u>		LENGTH OF STAY (in this place) <u>Life</u>		STREET ADDRESS <u>Shady Side, Md.</u>		STREET ADDRESS <u>Shady Side, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Rosie</u> (First) <u>Moulden</u> (Middle) <u></u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Oct</u> (Day) <u>26</u> (Year) <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 17 1880</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Churchton Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jacob Gross</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Blount</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Robert Moulden Shady Side</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
443X IMMEDIATE CAUSE (A) <u>Intense atherosclerotic hy furlonwts</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular disease</u>				The year			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Weak IV</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 13, 1959</u> to <u>Oct 26, 1959</u> , that I last saw the deceased alive on <u>Oct 26, 1959</u> , and that death occurred at <u>15:55</u> M. from the causes and on the date stated above.							
SIGNATURE <u>R. K. Richardson</u>				ADDRESS (Street, city, town, state) <u>110 CHERRY ST ANNAPOLIS MD, 10/28/59</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 28, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Franklin</u>		LOCATION (City, town, or county) (State) <u>Churchton Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>William J. HARRIS</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Benedict Hardisty</u>		ADDRESS <u>Galeville Ct</u>	
DATE <u>NOV 4 '59</u>							

# CERTIFICATE OF DEATH

1900

1. USUAL RESIDENCE HOUSE OR PLACE WHERE

DECEASED

2. PLACE OF DEATH

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

1. NAME OF DECEASED

2. SEX AND AGE AT DEATH

3. OCCUPATION

4. MARITAL STATUS

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JUDGE

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF

16. SIGNATURE OF

17. SIGNATURE OF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10960

10942

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOOLD</u> Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ARNOOLD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospital</u>		d. STREET ADDRESS <u>Box 550 Rt. #2 ARNOOLD</u>	
3. NAME OF DECEASED (Type or print) <u>ETHEL</u> First <u>A.</u> Middle <u>MURPHY</u> Last		4. DATE OF DEATH <u>10</u> <u>8</u> <u>1959</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-17-1899</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ADAM HORNER</u>		14. MOTHER'S MAIDEN NAME <u>MATILDA PERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. GEORGE WEHR</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/8</u> , 19 <u>57</u> , to <u>10/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/8</u> , 19 <u>59</u> , and that death occurred at <u>2:05 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST</u> DATE SIGNED <u>10/8/59</u> ACTUAL SIGNATURE <u>Richard W. Peeler</u> M.D. <u>ANNAPOLIS, MD.</u> PHYSICIAN'S NAME (Type) <u>RICHARD W. PEELER</u> <u>ANNAPOLIS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-10-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor + Sons Annapolis, Md.</u>		24. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

10000

CERTIFICATE OF DEATH

10000

HA Co

No.

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

HA Co

10943

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Homewood Conv'l. Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>S</b> Last <b>MYERS</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>23</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 7, 1889</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter, Ret.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Severn, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214-05-0721</b>			
17. INFORMANT <b>Mr John R. Myers-</b>				1705 Virginia Street <b>Annapolis, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>gen. carcinomatosis</b> <b>150X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>carcinoma of esophagus</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 10, 19 59</b> , to <b>Oct. 23, 19 59</b> that I last saw the deceased alive on <b>Oct. 22, 19 59</b> , and that death occurred at <b>9 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Amos Garrett Blvd., Annapolis</b>							
ACTUAL SIGNATURE <b>S. Borssuck</b> M.D. <b>Amos Garrett Blvd., Annapolis</b>				DATE SIGNED <b>10/26/59</b>			
PHYSICIAN'S NAME (Type) <b>S. Borssuck MD</b>				<b>Annapolis, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 26 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10051

CERTIFICATE OF DEATH

10051

State of New York, County of [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]



10993

CERTIFICATE OF DEATH

10962

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum Heights</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum Heights</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>629 Hammonds Ferry Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>ESTELLA</b> Last <b>NORTON</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>4,</b> Year <b>1959</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/18/1900</b>	9. AGE (In years last birthday) yrs. <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Martinsburg, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rubin F. DeLancey</b>				14. MOTHER'S MAIDEN NAME <b>Laura M. Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Carolyn Hill, daughter, above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC INSUFFICIENCY</b> DUE TO <b>CARCINOMATOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma uterus</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>1 year</b> <b>NOV. 1954</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia, Secondary to Carcinomatosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC. 1953</b> , to <b>OCT 4, 1959</b> , that I last saw the deceased alive on <b>OCT 4, 1959</b> , and that death occurred at <b>6:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>K. Krulevitz</b> <b>OCT. 6, 1959</b> M.D. <b>Kenneth Krulevitz M.D.</b> <b>400 N HILTON ST. BALTO, MD.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Richie Hwy., Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10045

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

10045

DECEASED NAME MARY ANN HARRIS		SEX FEMALE		AGE 65		DATE OF BIRTH OCT. 1, 1892		PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE		RELIGION METHODIST		MARRIAGE MARRIED		DATE OF MARRIAGE 1915		PLACE OF MARRIAGE BALTIMORE, MARYLAND		DECEASED NAME MARY ANN HARRIS		SEX FEMALE		AGE 65		DATE OF BIRTH OCT. 1, 1892		PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE		RELIGION METHODIST		MARRIAGE MARRIED		DATE OF MARRIAGE 1915		PLACE OF MARRIAGE BALTIMORE, MARYLAND	
DECEASED NAME MARY ANN HARRIS		SEX FEMALE		AGE 65		DATE OF BIRTH OCT. 1, 1892		PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE		RELIGION METHODIST		MARRIAGE MARRIED		DATE OF MARRIAGE 1915		PLACE OF MARRIAGE BALTIMORE, MARYLAND		DECEASED NAME MARY ANN HARRIS		SEX FEMALE		AGE 65		DATE OF BIRTH OCT. 1, 1892		PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE		RELIGION METHODIST		MARRIAGE MARRIED		DATE OF MARRIAGE 1915		PLACE OF MARRIAGE BALTIMORE, MARYLAND	
DECEASED NAME MARY ANN HARRIS		SEX FEMALE		AGE 65		DATE OF BIRTH OCT. 1, 1892		PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE		RELIGION METHODIST		MARRIAGE MARRIED		DATE OF MARRIAGE 1915		PLACE OF MARRIAGE BALTIMORE, MARYLAND		DECEASED NAME MARY ANN HARRIS		SEX FEMALE		AGE 65		DATE OF BIRTH OCT. 1, 1892		PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE		RELIGION METHODIST		MARRIAGE MARRIED		DATE OF MARRIAGE 1915		PLACE OF MARRIAGE BALTIMORE, MARYLAND	
DECEASED NAME MARY ANN HARRIS		SEX FEMALE		AGE 65		DATE OF BIRTH OCT. 1, 1892		PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE		RELIGION METHODIST		MARRIAGE MARRIED		DATE OF MARRIAGE 1915		PLACE OF MARRIAGE BALTIMORE, MARYLAND		DECEASED NAME MARY ANN HARRIS		SEX FEMALE		AGE 65		DATE OF BIRTH OCT. 1, 1892		PLACE OF BIRTH BALTIMORE, MARYLAND		RACE WHITE		RELIGION METHODIST		MARRIAGE MARRIED		DATE OF MARRIAGE 1915		PLACE OF MARRIAGE BALTIMORE, MARYLAND	

10944

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Anne Arundel General</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Victoria</u> d. STREET ADDRESS <u>Yatten Farm</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Jewett</u> Last <u>Orth</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 13, 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	11. PLACE OF BIRTH (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry J. Orth, Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Ann Blackston</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>	
16. SOCIAL SECURITY NO. <u>Harriet C. Orth</u>		17. ADDRESS <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Posterior Myocardial Infarction</u> DUE TO <u>Cornary artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>8-10 yrs.</u> (b) <u>8-10 yrs.</u> (c) <u>8-10 yrs.</u>		INTERVAL BETWEEN ONSET OF DEATH <u>2-3 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ch. Bronchitis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-27-59</u> , to <u>10-28-59</u> , that I last saw the deceased alive on <u>10-27-59</u> , and that death occurred <u>USA</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>121 Cathedral St</u> DATE SIGNED <u>10-24-59</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-27-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Shipley &amp; Sons Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 29 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10003

CERTIFICATE OF DEATH

10004

1

## CERTIFICATE OF DEATH

Reg. Dist. No.

10945

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>102 Roosevelt Court</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>S.</b> Last <b>OWEN</b>		4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>James D. Owen</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Worden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>David H. Owen #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>58</b> , to <b>10-17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-17</b> , 19 <b>59</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James R. Martin</b>		ADDRESS (Street, city or town, state) <b>6 Shaw St., Annapolis, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James R. Martin</b>		DATE <b>10/19/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-20-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Edwards Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Layton &amp; Sons</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 21 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

10345

NAME (Printed) \_\_\_\_\_

AGE \_\_\_\_\_

SEX \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

PLACE OF BIRTH \_\_\_\_\_

CAUSE OF DEATH \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_

TIME \_\_\_\_\_

PLACE \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_

PLACE OF DEATH \_\_\_\_\_

TIME \_\_\_\_\_

PLACE \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_

PLACE OF DEATH \_\_\_\_\_

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10965

10946

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen'l. Hosp.</u>				d. STREET ADDRESS <u>322 Roosevelt Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Clyde W. Owens</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Oct. 13, 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>21 April 1895</u>	
9. AGE (In years lost birthday) <u>64 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Trans. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>(Unknown)</u>				14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>W.W. 2 213-05-9076</u>		INFORMANT <u>Mrs. Elita M. Owens</u>	
Address <u>Same As #2</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism?</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior Myocardial Infarction 11 days</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Herpes Zoster</u> (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that I attended the deceased from <u>10-2-59</u> , 19 <u>59</u> , to <u>10-13-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-13-59</u> , 19____, and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>121 Cathedral St - 107305</u>				DATE SIGNED <u>Frank M. Shipley</u>			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>				M.D. <u>Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>				<u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>17 Oct. 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 19 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

CERTIFICATE OF DEATH

TORAS

1

1  
FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10966

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>10947</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>10</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>In front of 1193 Tyler Avenue</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b> d. STREET ADDRESS <b>1200 Brashears Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANCIS</b> Middle <b>GRIFFITH</b> Last <b>OWENS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1903</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b>	11. IF UNDER 24 HRS. Hours <b>56</b> Min. <b>56</b>
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Greyhound Bus Lines</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bus Driver</b>	
13. FATHER'S NAME <b>Charles G. Owens</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Owens</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>*</b>		16. SOCIAL SECURITY NO. <b>16-000000000</b>	
17. INFORMANT <b>Betty L. Owens # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Bradley King, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10/14/59</b>	
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/17/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>	22d. LOCATION (City, town, or country) (State) <b>Annapolis, Md.</b>
23. FUNERAL DIRECTOR <b>John M. Taylor and Sons</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10967

Reg. Dist. No.

10948

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>10</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>129 Severn Ave.</b>			d. STREET ADDRESS <b>129 Severn Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS F PATTERSON</b>			4. DATE OF DEATH Month Day Year <b>OCTOBER 1, 19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1897</b>	9. AGE (in years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Male practical nurse, Ret. General Hospital</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lima, Ohio</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>287 05 2110</b>		17. INFORMANT Address <b>Personal papers of Deceased</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC DISEASE</b> <b>434.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Natural causes</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>X 6</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(County) (State)</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Elmer G. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>October 1, 1959</b>	
EXAMINER'S NAME (Type) <b>Elmer G. Linhardt</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 3, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial Cemet</b>	
22d. LOCATION (City, town, or county) <b>Annapolis, Maryland</b>		22e. ADDRESS <b>Hopping Funeral Home</b>		22f. ADDRESS <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		24a. REC'D BY REGISTRAR <b>DATE OCT 6 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX	
DATE OF DEATH		PLACE OF DEATH		CITY	
OCCUPATION		EDUCATION		RELIGION	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE	
SYMPTOMS		TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY		PHYSICAL EXAMINATION	
LABORATORY EXAMINATIONS		RADIOLOGICAL EXAMINATIONS		PATHOLOGICAL EXAMINATIONS	
SIGNATURE OF EXAMINER		DATE		PLACE	
OFFICIAL SEAL		NOTARY SEAL		WITNESSES	
FAMILY SIGNATURE		FAMILY ADDRESS		FAMILY PHONE	
FAMILY DOCTOR		FAMILY HISTORY		FAMILY SOCIAL HISTORY	
FAMILY PHYSICAL EXAMINATION		FAMILY LABORATORY EXAMINATIONS		FAMILY RADIOLOGICAL EXAMINATIONS	
FAMILY PATHOLOGICAL EXAMINATIONS		FAMILY SIGNATURE		FAMILY DATE	
FAMILY OFFICIAL SEAL		FAMILY NOTARY SEAL		FAMILY WITNESSES	
FAMILY FAMILIAR SIGNATURE		FAMILY FAMILIAR ADDRESS		FAMILY FAMILIAR PHONE	
FAMILY FAMILIAR DOCTOR		FAMILY FAMILIAR HISTORY		FAMILY FAMILIAR SOCIAL HISTORY	
FAMILY FAMILIAR PHYSICAL EXAMINATION		FAMILY FAMILIAR LABORATORY EXAMINATIONS		FAMILY FAMILIAR RADIOLOGICAL EXAMINATIONS	
FAMILY FAMILIAR PATHOLOGICAL EXAMINATIONS		FAMILY FAMILIAR SIGNATURE		FAMILY FAMILIAR DATE	
FAMILY FAMILIAR OFFICIAL SEAL		FAMILY FAMILIAR NOTARY SEAL		FAMILY FAMILIAR WITNESSES	



10949

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>Annapolis</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>Annapolis</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Annapolis General Hosp.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> <b>Maryland</b> b. COUNTY <b>Glenburnie</b> <b>Anne Ar.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Freetown</b> d. STREET ADDRESS <b>Box 318</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah E. Pearman</b>				4. DATE OF DEATH Month Day Year <b>Oct. 25, 1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1917</b> <b>Oct. 3, 1917</b>		9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Freetowne Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Brown</b>				14. MOTHER'S MAIDEN NAME <b>Luvenia Brady</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address <b>Thomas Pearman Box 318 Freetown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastasis to Vital Organs</b> <b>171X</b> DUE TO <b>Carcinoma of Cervix</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>9-26-59</b> , 19 <b>59</b> , to <b>10-25-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10-25-59</b> , 19 <b>59</b> , and that death occurred at <b>9 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>A. T. Allen</b> M.D. <b>66 Crickfield St</b> PHYSICIAN'S NAME (Type) <b>A T ALLEN</b> <b>Annapolis, Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10/28/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Marley Neck Church Yd.</b>		22d. LOCATION (City, town, or county) (State) <b>Marley Neck Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Isaiah L. Brown &amp; Son 108 W. Montgomery St.</b>		ADDRESS <b>108 W. Montgomery St.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krawak</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

110003

CERTIFICATE OF DEATH

10042

Place of Birth

Virginia

Age

Freeborn

Box 118

Polio (Genital) - sep.

Person

Jan

1917

Feb. 3, 1917

C

12

Residence No.

Love's Body

Major Brown

Thomas Brown, Box 118 Freeborn, Va.

Copy Made of Copy Made of

State of Virginia, Department of Health

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10969

Reg. Dist. No.

10950

1. PLACE OF DEATH a. COUNTY <u>A.A.Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN lb <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>309 ADAMS St.</u>		d. STREET ADDRESS <u>309 ADAMS St.</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>H.</u> Last <u>PHILLIPS</u>		4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>26</u> Days <u>26</u> Hours <u>26</u> Min. <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. N.E.E.S.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY SERVICE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES H. PHILLIPS</u>		14. MOTHER'S MAIDEN NAME <u>EMMA ANN DALE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>WILBUR R. PHILLIPS</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROTIC CORONARY ARTERY DIS.</u> DUE TO (c) <u>HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MINUTES</u> <u>5 YEARS</u> <u>5 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 MAY, 1957</u> , to <u>10-31, 1957</u> , that I last saw the deceased alive on <u>10-27, 1957</u> , and that death occurred at <u>11P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>41 Southgate AVE</u> <u>11/3/59</u>	
PHYSICIAN'S NAME (Type) <u>ANNAPOLIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Edward S. Beck</u>	

CERTIFICATE OF DEATH

10078

1. NAME OF DECEASED <b>JOHN A. SMITH</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>		4. DATE OF BIRTH <b>1912</b>	
5. PLACE OF BIRTH <b>NEW YORK</b>		6. OCCUPATION <b>CLERK</b>		7. MARITAL STATUS <b>MARRIED</b>		8. DATE OF DEATH <b>1958</b>	
9. PLACE OF DEATH <b>HOME</b>		10. CAUSE OF DEATH <b>HEART DISEASE</b>		11. MANNER OF DEATH <b>NATURAL</b>		12. SIGNATURE OF PHYSICIAN <b>J. H. BROWN</b>	
13. SIGNATURE OF NEXT OF KIN <b>MRS. J. A. SMITH</b>		14. SIGNATURE OF WITNESSES <b>W. H. JONES, D. E. WHITE</b>		15. SIGNATURE OF REGISTRAR <b>W. H. JONES</b>		16. SIGNATURE OF CLERK <b>D. E. WHITE</b>	
17. PLACE OF INTERMENT <b>CATHOLIC CHURCH</b>		18. NAME OF CEMETERY <b>ST. MARY'S</b>		19. NAME OF CLERGYMAN <b>FATHER J. J. O'BRIEN</b>		20. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
21. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		22. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		23. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		24. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
25. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		26. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		27. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		28. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
29. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		30. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		31. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		32. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
33. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		34. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		35. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		36. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
37. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		38. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		39. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		40. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
41. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		42. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		43. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		44. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
45. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		46. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		47. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		48. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
49. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		50. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		51. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		52. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
53. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		54. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		55. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		56. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
57. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		58. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		59. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		60. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
61. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		62. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		63. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		64. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
65. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		66. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		67. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		68. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
69. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		70. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		71. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		72. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
73. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		74. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		75. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		76. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
77. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		78. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		79. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		80. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
81. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		82. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		83. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		84. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
85. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		86. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		87. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		88. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
89. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		90. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		91. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		92. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
93. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		94. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		95. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		96. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	
97. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		98. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		99. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>		100. NAME OF FUNERAL HOME <b>JOHN'S FUNERAL HOME</b>	

NOTED BY CLERK

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. MARITAL STATUS  
8. DATE OF DEATH  
9. PLACE OF DEATH  
10. CAUSE OF DEATH  
11. MANNER OF DEATH  
12. SIGNATURE OF PHYSICIAN  
13. SIGNATURE OF NEXT OF KIN  
14. SIGNATURE OF WITNESSES  
15. SIGNATURE OF REGISTRAR  
16. SIGNATURE OF CLERK  
17. PLACE OF INTERMENT  
18. NAME OF CEMETERY  
19. NAME OF CLERGYMAN  
20. NAME OF FUNERAL HOME  
21. NAME OF FUNERAL HOME  
22. NAME OF FUNERAL HOME  
23. NAME OF FUNERAL HOME  
24. NAME OF FUNERAL HOME  
25. NAME OF FUNERAL HOME  
26. NAME OF FUNERAL HOME  
27. NAME OF FUNERAL HOME  
28. NAME OF FUNERAL HOME  
29. NAME OF FUNERAL HOME  
30. NAME OF FUNERAL HOME  
31. NAME OF FUNERAL HOME  
32. NAME OF FUNERAL HOME  
33. NAME OF FUNERAL HOME  
34. NAME OF FUNERAL HOME  
35. NAME OF FUNERAL HOME  
36. NAME OF FUNERAL HOME  
37. NAME OF FUNERAL HOME  
38. NAME OF FUNERAL HOME  
39. NAME OF FUNERAL HOME  
40. NAME OF FUNERAL HOME  
41. NAME OF FUNERAL HOME  
42. NAME OF FUNERAL HOME  
43. NAME OF FUNERAL HOME  
44. NAME OF FUNERAL HOME  
45. NAME OF FUNERAL HOME  
46. NAME OF FUNERAL HOME  
47. NAME OF FUNERAL HOME  
48. NAME OF FUNERAL HOME  
49. NAME OF FUNERAL HOME  
50. NAME OF FUNERAL HOME  
51. NAME OF FUNERAL HOME  
52. NAME OF FUNERAL HOME  
53. NAME OF FUNERAL HOME  
54. NAME OF FUNERAL HOME  
55. NAME OF FUNERAL HOME  
56. NAME OF FUNERAL HOME  
57. NAME OF FUNERAL HOME  
58. NAME OF FUNERAL HOME  
59. NAME OF FUNERAL HOME  
60. NAME OF FUNERAL HOME  
61. NAME OF FUNERAL HOME  
62. NAME OF FUNERAL HOME  
63. NAME OF FUNERAL HOME  
64. NAME OF FUNERAL HOME  
65. NAME OF FUNERAL HOME  
66. NAME OF FUNERAL HOME  
67. NAME OF FUNERAL HOME  
68. NAME OF FUNERAL HOME  
69. NAME OF FUNERAL HOME  
70. NAME OF FUNERAL HOME  
71. NAME OF FUNERAL HOME  
72. NAME OF FUNERAL HOME  
73. NAME OF FUNERAL HOME  
74. NAME OF FUNERAL HOME  
75. NAME OF FUNERAL HOME  
76. NAME OF FUNERAL HOME  
77. NAME OF FUNERAL HOME  
78. NAME OF FUNERAL HOME  
79. NAME OF FUNERAL HOME  
80. NAME OF FUNERAL HOME  
81. NAME OF FUNERAL HOME  
82. NAME OF FUNERAL HOME  
83. NAME OF FUNERAL HOME  
84. NAME OF FUNERAL HOME  
85. NAME OF FUNERAL HOME  
86. NAME OF FUNERAL HOME  
87. NAME OF FUNERAL HOME  
88. NAME OF FUNERAL HOME  
89. NAME OF FUNERAL HOME  
90. NAME OF FUNERAL HOME  
91. NAME OF FUNERAL HOME  
92. NAME OF FUNERAL HOME  
93. NAME OF FUNERAL HOME  
94. NAME OF FUNERAL HOME  
95. NAME OF FUNERAL HOME  
96. NAME OF FUNERAL HOME  
97. NAME OF FUNERAL HOME  
98. NAME OF FUNERAL HOME  
99. NAME OF FUNERAL HOME  
100. NAME OF FUNERAL HOME

10951

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>D.</u> Last <u>Reed</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15-1909</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mgr. J.C. Murphy Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mgr. J.C. Murphy Store</u>	
11. BIRTHPLACE (State or foreign country) <u>W. R. Reesport Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harry L. Reed</u>		14. MOTHER'S MAIDEN NAME <u>Elinabeth Ballins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2</u>	
17. INFORMANT <u>Margaret L. Reed</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CORONARY/ARTERY DISEASE</u> DUE TO (c) <u>1 YEAR</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PREVIOUS CORONARY OCCLUSION JUNE 1957</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>58</u> , to <u>4 OCT</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1 OCT</u> , 19 <u>59</u> , and that death occurred at <u>12:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.			
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		<u>Annapolis Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct 6-59</u>	<u>Glen Haven Cem</u>	<u>Glen Burnie Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sins</u> ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles E. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10972

10952

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis - Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rhoda</b> Middle <b>P.</b> Last <b>ROHAN</b>		4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1899</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES SNYDER</b>		14. MOTHER'S MAIDEN NAME <b>KATIE WILLIAMS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Louis FUELNER</b> Address <b># 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery sclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>5 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 1955, to <b>October</b> , 1959, that I last saw the deceased alive on <b>Oct 22</b> , 1959, and that death occurred at <b>10 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 Cathedral St., Annapolis, Md.</b> DATE SIGNED <b>10/23/59</b> ACTUAL SIGNATURE <b>John C. Hedeman</b> M.D. PHYSICIAN'S NAME (Type) <b>John C. Hedeman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-26-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 27 '59</b>	
ADDRESS <b>Annapolis, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

1982

DECEASED - NAME

DECEASED - SEX

DECEASED - RACE

DATE

TIME

PLACE

AGE

DECEASED - OCCUPATION

DECEASED - CAUSE OF DEATH

DECEASED - SIGNATURE

DECEASED - SIGNATURE

DECEASED - SIGNATURE

DECEASED - SIGNATURE

DECEASED - SIGNATURE

DECEASED - SIGNATURE

DECEASED - SIGNATURE

DECEASED - SIGNATURE

DECEASED - SIGNATURE

DECEASED - SIGNATURE

Rev. William Schmeiser

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH

a. COUNTY A. A.

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Md.

b. COUNTY Balto.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Annapolis

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Towson

0355-2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

A. A. County Hosp.

d. STREET ADDRESS

227 Linden Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

## 3. NAME OF DECEASED (Type or print)

First Middle Last  
Rev. William Schmeiser

## 4. DATE OF DEATH

Month Day Year  
Oct. 17, 19 59

## 5. SEX

male

## 6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

## 8. DATE OF BIRTH

May 31, 1889

## 9. AGE (In years last birthday)

70 yrs.

## 10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clergyman

## 10b. KIND OF BUSINESS OR INDUSTRY

Methodist Church

## 11. BIRTHPLACE (State or foreign country)

Md.

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

Henry Schmeiser

## 14. MOTHER'S MAIDEN NAME

Caroline Brendel

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

no

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

219-01-8932

## INFORMANT

Address

Annapolis, Md.

Mr. Leroy Schmeiser - Route 2, Box 57

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

442X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause lost.

DUE TO

(b)

(c)

## INTERVAL BETWEEN ONSET AND DEATH

2 days

57 min.

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a)

Ca of prostate, Diarrhea cfr. ACVD Ind

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. p. m.20d. INJURY OCCURRED  
While ☐ Not while ☐  
of work of work

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 9-10-59, 19 59, to 10-17-59, that I last saw the deceased alive on 10-17-59, and that death occurred at 3 P. M. from the causes and on the date stated above.

## ACTUAL SIGNATURE

Frank M. Shipley M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

171 Catheedral St 10-17-59

## PHYSICIAN'S NAME (Type)

Frank M Shipley

Annapolis, Md

## 22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

10/20/59

## 22c. NAME OF CEMETERY OR CREMATORY

Glen Haven Mem. Pk.

## 22d. LOCATION (City, town, or county)

Glen Burnie, Md.

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Am. J. Lickner &amp; Sons - Baltor 17 Md

## 24a. REC'D BY REGISTRAR

DATE OCT 19 '59

## 24b. REGISTRAR'S SIGNATURE

William L. Piana

CERTIFICATE OF DEATH

1902

1902

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Cause of death: \_\_\_\_\_

8. Signature of physician: \_\_\_\_\_

9. Signature of registrar: \_\_\_\_\_

10. Date of registration: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10994

CERTIFICATE OF DEATH

10974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Orange</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Orlando</b> <b>48X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>				d. STREET ADDRESS <b>539 Kittridge Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>BERT</b> Middle <b>-</b> Last <b>SHANNON SR</b>		4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>19 59</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 March 1879</b>				
9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocer</b>					
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Andrew Shannon</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>234-2-1542</b>					
17. INFORMANT <b>Son, Bert Shamon Jr</b>		Address <b>3957 Brooklyn Ave Balto, Md</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>one month</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>3 Oct</b> , 19 <b>59</b> , to <b>19</b> , that I last saw the deceased alive on <b>3 Oct</b> , 19 <b>59</b> , and that death occurred at <b>0045 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>J. B. Zachary</b> M.D. <b>US Army Hospital</b> <b>3 Oct 59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>J. B. ZACHARY, Capt., M.C.</b> <b>Ft Geo G. Meade, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10'7'59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Mem. Park</b>	22d. LOCATION (City, town, or county) (State) <b>XX Orlando, Florida</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 7 '59</b>					
24b. REGISTRAR'S SIGNATURE <i>Charles A. Harris</i>							





VS. A15ME  
5M 7/59

## 10975

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN b. <b>10954</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenock</b> d. STREET ADDRESS <b>X</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BERNARD SMITH, Sr.</b> First Middle Last 4. DATE OF DEATH <b>October 25 1959</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>Colored</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>3-7-22</b> 9. AGE (In years last birthday) <b>37</b> 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b> 11. BIRTHPLACE (State or foreign country) <b>md</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.-1.</b>		13. FATHER'S NAME <b>Oliver Smith</b> 14. MOTHER'S MAIDEN NAME <b>Florence Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>1914-26-4915</b> 16. SOCIAL SECURITY NO. <b>Hagner Booth</b> 17. INFORMANT <b>Dwings mcl</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound of Head.</b> 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Shot in head.</b> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot in head.</b> 20c. TIME OF INJURY Month, Day, Year Hour <b>9:00</b> p.m. <b>10/25 1959</b> 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20f. (City or town) (County) (State) <b>Greenock A.A. Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>10/27/59</b> EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b> Address (Street, city, town, or county) <b>1348 N. Calhoun St</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>10-29-59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Not Hope cem</b> 22d. LOCATION (City, town, or country) (State) <b>Sunderland Robert Co md</b>		23. FUNERAL DIRECTOR <b>Geo G. Nelson</b> 24a. REC'D BY REGISTRAR <b>NOV 3 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

THE STATE  
DEPT. OF HEALTH

10/25/32

10/25/32

Admission to General Hospital

RECORD

WITH ST.

October 25 - 32

Colored

Male

1

Shannon found of blood.

Shot in hand.

10/25/32

10/25/32

10/25/32

10/25/32

Thomas S. Bell

Nov 1 - 32

10995

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN lb <b>24 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2716 W. Fairmount Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Katie</b> Middle <b>Sutton</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>10</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 28, 1881</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b>		11. IF UNDER 24 HRS. Days <b>1</b>		12. IF UNDER 1 YEAR Hours <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Richard Sutton</b>				14. MOTHER'S MAIDEN NAME <b>Harriet</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Senility</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. ----- <b>19</b>				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from <b>10/6</b> , 19 <b>59</b> , to <b>10/30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/30</b> , 19 <b>59</b> and that death occurred at <b>11:50</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>10/30/59</b> ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b> M.D. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D. Crownsville State Hospital, Md.</b> <b>10/30/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried 10/4/59 Mt Auburn</b>				22b. DATE THEREOF <b>10/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baldwin</b>	
22d. LOCATION (City, town, or county) <b>Baldwin</b>				22e. (State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Corpe 512 Calverton</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William R. Reissman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10032

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

10032

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

10996

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1213 James St</u>	
b. CITY OR TOWN (If outside corporate limits, write nearest town) <u>Millersville Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Salem Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Amelia Sarah Straub</u>		4. DATE OF DEATH Month Day Year <u>Oct 30 - 19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 8 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard Mills</u>		14. MOTHER'S MAIDEN NAME <u>Mills</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-36-2751</u>	
17. INFORMANT <u>Carl W. Straub</u> Address <u>305 W. Furnace Branch Rd - Glen Burnie Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Latent Pneumonia</u> DUE TO (b) <u>Cerebral Thrombosis -</u> DUE TO (c) <u>Arteriosclerotic Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/8/59</u> to <u>10/30-59</u> , that I last saw the deceased alive on <u>10/29/59</u> , and that death occurred at <u>3:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Lipskey</u> M.D.		ADDRESS (Street, city or town, state) <u>Odenton Md</u>	
DATE SIGNED <u>10/30/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Goulson</u> ADDRESS <u>2359 Wash. Blvd. Balto. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 2 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Christina D. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10086

For use by

DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF REGISTRAR

SIGNATURE OF REGISTRAR

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF WITNESS

SIGNATURE OF WITNESS

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF WITNESS

SIGNATURE OF WITNESS

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF WITNESS

SIGNATURE OF WITNESS

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF WITNESS

SIGNATURE OF WITNESS

DATE OF SIGNATURE

PLACE OF SIGNATURE



10997

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>A. Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. LENGTH OF STAY IN 1b <b>1 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 Overhill Rd.</b>				d. STREET ADDRESS <b>829 West St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert Francis</b> Middle <b>SUITE</b> Last				4. DATE OF DEATH Month <b>October</b> Day <b>21</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 Aug. 1871</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mortician(ret)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>		11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>yes</b>							
13. FATHER'S NAME <b>Charles Montgomery Suite(dec)</b>				14. MOTHER'S MAIDEN NAME <b>Mary Virginia Scheckells(dec)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs Mary Mendez(daughter) 11 Overhill Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>610x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertrophy of Prostate</b> DUE TO (c) <b>Growth on Epiglottis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>2 yrs</b> <b>2 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Senility, Slight Strokes.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No accident or injury.</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>59</b>	
20f. (City or town) <b>Present time</b>				(County)		(State)	
21. I certify that I attended the deceased from <b>7 Oct.</b> , 19 <b>59</b> to <b>Present time</b> , that I last saw the deceased alive on <b>17 October 19 59</b> , and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>901 Edgerly Rd., Glen Burnie, Md.</b> DATE SIGNED <b>21 October 1959</b>							
ACTUAL SIGNATURE <b>H.F. Manuzak</b>				M.D. <b>H.F. Manuzak M.D.</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bedar Bluff Cent</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Golm M. Layla Dms</b>				ADDRESS <b>Annapolis Md</b>		24a. REC'D BY REGISTRAR <b>DATE OCT 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10979

Reg. Dist. No.

10998

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Maryland</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			c. LENGTH OF STAY IN 1b <u>30 minutes</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dayton</u> <span style="float: right;">72X-3</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maryland Yacht Club, Rock Creek</u>				d. STREET ADDRESS <u>4241 Cleveland Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Steven H. Sunstie, Sr</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>October 20th, 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1892</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Restaurant operator.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Ishphening, Michigan.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Steven H. Sunstie</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, Marine, World War #1</u>			16. SOCIAL SECURITY NO. <u>#1</u>		17. INFORMANT Address <u>Mr. Robert E. Derr (Brother in law)</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/20/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 23., 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dayton Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Dayton, Ohio</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. H. Davidson, Laurel Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

100379

FILE NO.

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS MARRIAGES</p> <p>12. PREVIOUS DEATHS</p> <p>13. PREVIOUS ILLNESSES</p> <p>14. PREVIOUS SURGERIES</p> <p>15. PREVIOUS TRAUMAS</p> <p>16. PREVIOUS DRUGS</p> <p>17. PREVIOUS ALCOHOL</p> <p>18. PREVIOUS TOBACCO</p> <p>19. PREVIOUS OTHER</p> <p>20. PREVIOUS OTHER</p> <p>21. PREVIOUS OTHER</p> <p>22. PREVIOUS OTHER</p> <p>23. PREVIOUS OTHER</p> <p>24. PREVIOUS OTHER</p> <p>25. PREVIOUS OTHER</p> <p>26. PREVIOUS OTHER</p> <p>27. PREVIOUS OTHER</p> <p>28. PREVIOUS OTHER</p> <p>29. PREVIOUS OTHER</p> <p>30. PREVIOUS OTHER</p> <p>31. PREVIOUS OTHER</p> <p>32. PREVIOUS OTHER</p> <p>33. PREVIOUS OTHER</p> <p>34. PREVIOUS OTHER</p> <p>35. PREVIOUS OTHER</p> <p>36. PREVIOUS OTHER</p> <p>37. PREVIOUS OTHER</p> <p>38. PREVIOUS OTHER</p> <p>39. PREVIOUS OTHER</p> <p>40. PREVIOUS OTHER</p> <p>41. PREVIOUS OTHER</p> <p>42. PREVIOUS OTHER</p> <p>43. PREVIOUS OTHER</p> <p>44. PREVIOUS OTHER</p> <p>45. PREVIOUS OTHER</p> <p>46. PREVIOUS OTHER</p> <p>47. PREVIOUS OTHER</p> <p>48. PREVIOUS OTHER</p> <p>49. PREVIOUS OTHER</p> <p>50. PREVIOUS OTHER</p> <p>51. PREVIOUS OTHER</p> <p>52. PREVIOUS OTHER</p> <p>53. PREVIOUS OTHER</p> <p>54. PREVIOUS OTHER</p> <p>55. PREVIOUS OTHER</p> <p>56. PREVIOUS OTHER</p> <p>57. PREVIOUS OTHER</p> <p>58. PREVIOUS OTHER</p> <p>59. PREVIOUS OTHER</p> <p>60. PREVIOUS OTHER</p> <p>61. PREVIOUS OTHER</p> <p>62. PREVIOUS OTHER</p> <p>63. PREVIOUS OTHER</p> <p>64. PREVIOUS OTHER</p> <p>65. PREVIOUS OTHER</p> <p>66. PREVIOUS OTHER</p> <p>67. PREVIOUS OTHER</p> <p>68. PREVIOUS OTHER</p> <p>69. PREVIOUS OTHER</p> <p>70. PREVIOUS OTHER</p> <p>71. PREVIOUS OTHER</p> <p>72. PREVIOUS OTHER</p> <p>73. PREVIOUS OTHER</p> <p>74. PREVIOUS OTHER</p> <p>75. PREVIOUS OTHER</p> <p>76. PREVIOUS OTHER</p> <p>77. PREVIOUS OTHER</p> <p>78. PREVIOUS OTHER</p> <p>79. PREVIOUS OTHER</p> <p>80. PREVIOUS OTHER</p> <p>81. PREVIOUS OTHER</p> <p>82. PREVIOUS OTHER</p> <p>83. PREVIOUS OTHER</p> <p>84. PREVIOUS OTHER</p> <p>85. PREVIOUS OTHER</p> <p>86. PREVIOUS OTHER</p> <p>87. PREVIOUS OTHER</p> <p>88. PREVIOUS OTHER</p> <p>89. PREVIOUS OTHER</p> <p>90. PREVIOUS OTHER</p> <p>91. PREVIOUS OTHER</p> <p>92. PREVIOUS OTHER</p> <p>93. PREVIOUS OTHER</p> <p>94. PREVIOUS OTHER</p> <p>95. PREVIOUS OTHER</p> <p>96. PREVIOUS OTHER</p> <p>97. PREVIOUS OTHER</p> <p>98. PREVIOUS OTHER</p> <p>99. PREVIOUS OTHER</p> <p>100. PREVIOUS OTHER</p>		<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS MARRIAGES</p> <p>12. PREVIOUS DEATHS</p> <p>13. PREVIOUS ILLNESSES</p> <p>14. PREVIOUS SURGERIES</p> <p>15. PREVIOUS TRAUMAS</p> <p>16. PREVIOUS DRUGS</p> <p>17. PREVIOUS ALCOHOL</p> <p>18. PREVIOUS TOBACCO</p> <p>19. PREVIOUS OTHER</p> <p>20. PREVIOUS OTHER</p> <p>21. PREVIOUS OTHER</p> <p>22. PREVIOUS OTHER</p> <p>23. PREVIOUS OTHER</p> <p>24. PREVIOUS OTHER</p> <p>25. PREVIOUS OTHER</p> <p>26. PREVIOUS OTHER</p> <p>27. PREVIOUS OTHER</p> <p>28. PREVIOUS OTHER</p> <p>29. PREVIOUS OTHER</p> <p>30. PREVIOUS OTHER</p> <p>31. PREVIOUS OTHER</p> <p>32. PREVIOUS OTHER</p> <p>33. PREVIOUS OTHER</p> <p>34. PREVIOUS OTHER</p> <p>35. PREVIOUS OTHER</p> <p>36. PREVIOUS OTHER</p> <p>37. PREVIOUS OTHER</p> <p>38. PREVIOUS OTHER</p> <p>39. PREVIOUS OTHER</p> <p>40. PREVIOUS OTHER</p> <p>41. PREVIOUS OTHER</p> <p>42. PREVIOUS OTHER</p> <p>43. PREVIOUS OTHER</p> <p>44. PREVIOUS OTHER</p> <p>45. PREVIOUS OTHER</p> <p>46. PREVIOUS OTHER</p> <p>47. PREVIOUS OTHER</p> <p>48. PREVIOUS OTHER</p> <p>49. PREVIOUS OTHER</p> <p>50. PREVIOUS OTHER</p> <p>51. PREVIOUS OTHER</p> <p>52. PREVIOUS OTHER</p> <p>53. PREVIOUS OTHER</p> <p>54. PREVIOUS OTHER</p> <p>55. PREVIOUS OTHER</p> <p>56. PREVIOUS OTHER</p> <p>57. PREVIOUS OTHER</p> <p>58. PREVIOUS OTHER</p> <p>59. PREVIOUS OTHER</p> <p>60. PREVIOUS OTHER</p> <p>61. PREVIOUS OTHER</p> <p>62. PREVIOUS OTHER</p> <p>63. PREVIOUS OTHER</p> <p>64. PREVIOUS OTHER</p> <p>65. PREVIOUS OTHER</p> <p>66. PREVIOUS OTHER</p> <p>67. PREVIOUS OTHER</p> <p>68. PREVIOUS OTHER</p> <p>69. PREVIOUS OTHER</p> <p>70. PREVIOUS OTHER</p> <p>71. PREVIOUS OTHER</p> <p>72. PREVIOUS OTHER</p> <p>73. PREVIOUS OTHER</p> <p>74. PREVIOUS OTHER</p> <p>75. PREVIOUS OTHER</p> <p>76. PREVIOUS OTHER</p> <p>77. PREVIOUS OTHER</p> <p>78. PREVIOUS OTHER</p> <p>79. PREVIOUS OTHER</p> <p>80. PREVIOUS OTHER</p> <p>81. PREVIOUS OTHER</p> <p>82. PREVIOUS OTHER</p> <p>83. PREVIOUS OTHER</p> <p>84. PREVIOUS OTHER</p> <p>85. PREVIOUS OTHER</p> <p>86. PREVIOUS OTHER</p> <p>87. PREVIOUS OTHER</p> <p>88. PREVIOUS OTHER</p> <p>89. PREVIOUS OTHER</p> <p>90. PREVIOUS OTHER</p> <p>91. PREVIOUS OTHER</p> <p>92. PREVIOUS OTHER</p> <p>93. PREVIOUS OTHER</p> <p>94. PREVIOUS OTHER</p> <p>95. PREVIOUS OTHER</p> <p>96. PREVIOUS OTHER</p> <p>97. PREVIOUS OTHER</p> <p>98. PREVIOUS OTHER</p> <p>99. PREVIOUS OTHER</p> <p>100. PREVIOUS OTHER</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10999

## CERTIFICATE OF DEATH

## 10980

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.5em;">A.A. Co.</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.5em;">Md.</span> <span style="float: right;">b. COUNTY <span style="font-size: 1.5em;">A.A. Co.</span></span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.5em;">Harundale, Maryland</span>			c. LENGTH OF STAY IN 1b 			X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.5em;">Harundale, Maryland</span>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="font-size: 1.5em;">1617 Kimber Road</span>				d. STREET ADDRESS <span style="font-size: 1.5em;">1617 Kimber Road</span>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.5em;">LAURA</span> <span style="float: right;">First</span> <span style="font-size: 1.5em;">ISABELLE TAYLOR</span> <span style="float: right;">Middle</span> <span style="float: right;">Last</span>				<b>4. DATE OF DEATH</b> <span style="font-size: 1.5em;">October 11</span> <span style="float: right;">Month</span> <span style="float: right;">Day</span> <span style="float: right;">Year</span> <span style="font-size: 1.5em;">1959</span>					
5. SEX <span style="font-size: 1.5em;">FE</span>		6. COLOR OR RACE <span style="font-size: 1.5em;">W</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.5em;">Sept. 19, 1866</span>		9. AGE (In years last birthday) <span style="font-size: 1.5em;">93</span> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Housewife</span>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">U. S. A.</span>	
13. FATHER'S NAME <span style="font-size: 1.5em;">John Wray</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">Sarah Orem</span>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <span style="font-size: 1.5em;">no</span>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <span style="float: right;">Address</span> <span style="font-size: 1.5em;">Sidney T. Taylor 4136 Wilkens Avenue 29</span>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">Cerebral hemorrhage</span> <span style="font-size: 1.5em;">443X</span> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="font-size: 1.5em;">Hypertensive Cardiovascular</span> DUE TO (c) <span style="font-size: 1.5em;">Disease</span>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <span style="float: right;">19</span>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <span style="font-size: 1.5em;">October 7, 1959</span> , to <span style="font-size: 1.5em;">October 11, 1959</span> that I last saw the deceased alive on <span style="font-size: 1.5em;">October 10, 1959</span> , and that death occurred at <span style="font-size: 1.5em;">4:20 A.M.</span> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <span style="font-size: 1.5em;">Edmond I. Moushalek</span> M.D.				ADDRESS (Street, city or town, state) <span style="font-size: 1.5em;">2101 S. Ritchie Highway</span>				DATE SIGNED <span style="font-size: 1.5em;">Oct 11, 1959</span>	
PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">EDMOND I. MOUSHA BEK.</span>				SIGNATURE <span style="font-size: 1.5em;">Glen Burnie</span>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>		22b. DATE THEREOF <span style="font-size: 1.5em;">10/14/59</span>		22c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.5em;">Cedar Hill Cemetery</span>		22d. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Glen Burnie, Maryland</span>			
23. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.5em;">Howard H. Hubbard</span>				ADDRESS <span style="font-size: 1.5em;">4107 Wilkens Avenue</span>		24a. REC'D BY REGISTRAR DATE <span style="font-size: 1.5em;">OCT 15 '59</span>		24b. REGISTRAR'S SIGNATURE <span style="font-size: 1.5em;">Arthur S. Kraus</span>	

MEDICAL CERTIFICATION

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11000

CERTIFICATE OF DEATH

10981  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft Meade, USAH</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel 1641-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Army Hospital</b>				d. STREET ADDRESS <b>Apt-7 Laurel Manor Court</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Taylor (Infant Male)</b> , Middle <b>Steven</b> , Last <b>LeRoy</b>				4. DATE OF DEATH Month <b>October</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>13 Oct 1959</b>	
9. AGE (In years lost birthday) <b>— yrs.</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>		IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>FGGM, Md.</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward L. Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Rose Renda</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>---</b>		INFORMANT Address <b>Personnel Records, FGGM, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>18 October, 1959</b> , to <b>18 October, 1959</b> , that I last saw the deceased alive on <b>never saw pt. alive</b> , and that death occurred at <b>0210AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>C. Richard A. Gilbert</b> M.D. <b>1726 Eys St N.W. Wash D.C.</b> <b>18 Oct 1959</b>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <b>C. Richard A Gilbert</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/20/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Rose Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>York. Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley, Glen Burnie, Md.</b>				24a. REC'D BY REGISTRAR <b>OCT 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2050171XU1

12-81

11000

History

with family

History

2 days

History

History

History

History

History

History

History

History

History

History

History

History

History

History

History

History

History

11001

CERTIFICATE OF DEATH

10982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. River, Md.</i>				c. LENGTH OF STAY IN 1b <i>16 Mos.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Senn's Nursing Home</i>				d. STREET ADDRESS <i>1st Mt. Road - Lake Shore</i>			
3. NAME OF DECEASED (Type or print) <i>Charlotte E. Thomas</i>				4. DATE OF DEATH <i>10/5/59</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>27 Jan 1880</i>	
9. AGE (In years last birthday) <i>79</i>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper (Ret)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Emerson Hotel</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>(Unknown) Wolfe</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Melvin Thomas - North Shore, Pasadena, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>605x Acute Cardiac Failure</i> DUE TO <i>Chronic Cystitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Paralysis - Residual</i> (b) <i>Sudden</i> (c) <i>Bye</i>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>9/24/59</i> to <i>10/5/59</i> , that I last saw the deceased alive on <i>10/3/59</i> , and that death occurred at <i>Md.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Joseph Lipskey</i>				ADDRESS (Street, City or town, state) <i>10/5/59</i>			
PHYSICIAN'S NAME (Type) <i>JOSEPH LIPSKEY</i>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9 Oct. 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ormid Ridge</i>		22d. LOCATION (City, town, or county) (State) <i>Pasadena, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. V. Singletta</i>				ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR <i>OCT 9 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Charles E. Thomas</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11002

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>20 yrs. 5mo. 3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mayfield</b> 13x-2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle Last <b>Thorns</b>				4. DATE OF DEATH Month <b>10</b> Day <b>3</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1911</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis - Far Advanced</b> 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Mental Defective</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>79</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/30</b> , 19 <b>59</b> , to <b>10/3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10/3</b> , 19 <b>59</b> , and that death occurred at <b>10:50 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M. D.</b> M.D. <b>Crownsville State Hospital, Md.</b> <b>10/5/59</b> PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b> <b>Crownsville State Hospital, Md.</b> <b>10/5/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Remove</b>		22b. DATE THEREOF <b>10-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Maryland &amp; West Church</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Reese II</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton E. K...</b>	

80 of 1  
510  
150  
773  
M  
I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11003

## CERTIFICATE OF DEATH

10984

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>a.a.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 93, Manhattan Beach</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Manhattan Beach Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Severna Park Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLIFFORD William Tompkins</u> First Middle Last <u>58</u>		4. DATE OF DEATH <u>10-19-59</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19-Feb-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business - Radio</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>upper Maryland</u>	9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Bernard William Tompkins</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Forrest</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>5000</u>	
17. INFORMANT <u>Son</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1955</u> , 19, to <u>10-19-59</u> , that I last saw the deceased alive on <u>10-12-59</u> , 19, and that death occurred at <u>130</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>10-19-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>22 Oct-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawitz</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
MARRIED		SINGLE		MARRIED		SINGLE		MARRIED		SINGLE	
EDUCATION		SCHOOLING		OCCUPATION		INDUSTRY		TRADE		PROFESSION	
HIGH SCHOOL		12		CIVIL ENGINEER		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
APRIL 4, 1968		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		YES		JAMES EARL RAY	
DATE OF BURIAL		PLACE OF BURIAL		CEREMONY		FUNERAL HOME		COST		REMARKS	
APRIL 8, 1968		MEMPHIS, TENNESSEE		YES		JAMES EARL RAY		\$100.00		NO OTHER REMARKS	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 19

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10955

## CERTIFICATE OF DEATH

10985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A. 10985</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Round Bay Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Home</u> <u>Homewood Convalescent</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ida - Wilson Vang</u>		4. DATE OF DEATH <u>Oct. 28</u> 19 <u>59</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>08 23 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Madera Peru</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John T. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Jane Jopling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Daughter Mrs. Add</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen Arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> , 19 <u></u> to <u>present</u> 19 <u></u> , that I last saw the deceased alive on <u>10-18-59</u> , 19 <u></u> and that death occurred at <u>2 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u>		DATE SIGNED <u>10-28-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn, Severna Park</u>		ADDRESS (Street, city or town, state) <u>Severna Park, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickerson &amp; Sons - Baltimore</u>		24. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

10355

10355

2-2-1918

DATE OF DEATH  
1918

DECEASED

NAME OF DECEASED

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE CAUSE

DISSEMINATED

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

# 1 11004 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10986

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>none</i>		d. STREET ADDRESS <i>Old Odenton Rd Box 255</i>	
3. NAME OF DECEASED (Type or print) First <i>Richard</i> Middle <i>D.</i> Last <i>Wallace</i>		4. DATE OF DEATH Month <i>10</i> Day <i>24</i> Year <i>1959</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 17 1891</i>
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Clinton Tenn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>William Wallace</i>		14. MOTHER'S MAIDEN NAME <i>Belle Wallace Shinliver</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>220-22-8613</i>	
17. INFORMANT <i>Ona Wallace - old Odenton Md.</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis -</i> 420.1 DUE TO <i>Sclerotic Coricis Arteries - with</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Rheumatic Heart Disease -</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary Failure - compensated</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> p. m. <i>—</i> 19 <i>59</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>
21. I certify that I attended the deceased from <i>9/21</i> , 19 <i>57</i> , to <i>10/24</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>9/20</i> , 19 <i>59</i> , and that death occurred at <i>7:30</i> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Felix Gruenberg</i> M.D.		ADDRESS (Street, city or town, state) <i>P.O. Box 97 Odenton - Md.</i>	
PHYSICIAN'S NAME (Type) <i>Felix Gruenberg</i>		DATE SIGNED <i>10/24/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct. 27, 59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>Glen Burnie Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>—</i> ADDRESS <i>Hopping &amp; Kirkley, Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR <i>—</i> DATE <i>OCT 28 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



30812



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22 FilmG250 10-23-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

10987

10956

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hosp.</u>				1d. STREET ADDRESS <u>Eddye Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>May</u> Last <u>Ward</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 15 - 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Davidson</u>				14. MOTHER'S MAIDEN NAME <u>Jally Lawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>			
INFORMANT Address <u>Mrs Ruby Spence - Oakwood Rd. Gty Burnie</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BLACK PNEUMONIA</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL THROMBOSIS</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 DAYS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARKINSON'S DISEASE (PARALYSIS AGITANS)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10-8</u> , 19 <u>59</u> , to <u>10-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-18</u> , 19 <u>59</u> , and that death occurred at <u>3:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S Beck</u>				ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u> DATE SIGNED <u>10-18-59</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 21 - 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Walters - Pratt &amp; Stricker Sts</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>OCT 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

Baltimore 23, Md.

1688

1688

1688

1688

1688

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10988

11005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPE ST. CLAIRE</u>		c. LENGTH OF STAY IN 1b <u>300.4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROADVIEW DRIVE</u>		d. STREET ADDRESS <u>2025 Gough St.</u>	
3. NAME OF DECEASED (Type or print) <u>STANISLAWA (STELLA) WESOLOWSKI</u>		4. DATE OF DEATH <u>October 14 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank Lukowiak</u>		14. MOTHER'S MAIDEN NAME <u>Michalina Lukowiak ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Eva Adamski Broadview Drive A. A. Co. Md</u>		Address <u>Cape St. Claire</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation and failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile arteriosclerotic nephrosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis and hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 years or more</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-7</u> , 1959, to <u>10-14</u> , 1959, that I last saw the deceased alive on <u>10-13</u> , 1959, and that death occurred at <u>3:15</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Bertrand C. R. Gau</u>		M.D. <u>River Bay Road Cape St. Claire</u> <u>10/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Bertrand C. R. GAU</u>		<u>Rt. 4, Annapolis</u> <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co.</u> <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Win. S. Fialkowski</u>		ADDRESS <u>2007 Eastern Ave</u>	
24a. REC'D BY REGISTRAR <u>OCT 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11006

## CERTIFICATE OF DEATH

10989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>45 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		d. STREET ADDRESS <b>#106 "A" Street, S.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>#106 "A" Street, S.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>A.</b> Last <b>WOODFALL</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 Jan. 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Sec. (ret.)</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Sec. (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bld. &amp; Loan</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles W. Bloom</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kelley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Mrs. Betty Brandenburg</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardio - Vascular Disease (10 years)</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> to <b>28 Oct.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>27 October, 1959</b> , and that death occurred at <b>4: A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>#108 Central Ave., N.W.</b> DATE SIGNED <b>10/28/59</b>			
ACTUAL SIGNATURE <b>James S. Billingslea</b> M.D.		Glen Burnie, Maryland	
PHYSICIAN'S NAME (Type) <b>James S. Billingslea, M.D.</b>		Glen Burnie, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>31 Oct. 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brooklyn, RFD, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. J. Singleton</b>		ADDRESS <b>Glen Burnie, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

CERTIFICATE OF DEATH

11006

Reg. No. 110

1. NAME OF DECEASED

James B. Harrison

2. SEX

Male

3. AGE

68 years

4. PLACE OF BIRTH

St. Louis, Mo.

5. OCCUPATION

Retired

6. DATE OF DEATH

October 10, 1968

7. TIME OF DEATH

10:00 A.M.

8. CAUSE OF DEATH

Heart Disease

9. MANNER OF DEATH

Natural

10. SIGNATURE OF PHYSICIAN

Dr. J. B. Harrison

11. SIGNATURE OF REGISTRAR

James B. Harrison

12. SIGNATURE OF WITNESSES

James B. Harrison

13. SIGNATURE OF DECEASED

James B. Harrison

14. SIGNATURE OF DECEASED

James B. Harrison

15. SIGNATURE OF DECEASED

James B. Harrison



10957

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Box 189 Defence Highway</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>BOY</u> Last <u>ZAKRZEWSKI</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 14, 1959</u>
9. AGE (In years lost birthday) yrs. <u>13</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Zakrzewski</u>		14. MOTHER'S MAIDEN NAME <u>Roxie D. Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr Edward Zakrzewski- Father- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complications, severe</u> <u>560.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/14, 1959</u> , to <u>10/14, 1959</u> , that I last saw the deceased alive on <u>10/14, 1959</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Robert A. Riley</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Robert A. Riley MD</u> <u>69 Franklin Street, Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 15, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063181XU2

1930

CERTIFICATE OF DEATH

10052

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

DATE OF MARRIAGE: [illegible] PLACE OF MARRIAGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]